CJRR Web-Based Data Submission and Reports Tool, User Manual, 2015–2016

Standards and Data Submission

Canadian Institute for Health Information
Institut canadien d'information sur la santé

Our Vision

Better data. Better decisions.
Healthier Canadians.

Our Mandate

To lead the development and maintenance of comprehensive and integrated health information that enables sound policy and effective health system management that improve health and health care.

Our Values

Respect, Integrity, Collaboration, Excellence, Innovation

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1 Introduction

1.1 CJRR Background

The Canadian Joint Replacement Registry (CJRR) is a pan-Canadian information system for hip and knee replacement operations. Its mandate is to record and analyze clinical parameters and outcomes of primary and revision hip and knee replacement operations over time. The registry was developed through a joint effort between the Canadian Institute for Health Information (CIHI) and orthopedic surgeons in Canada. The goal of CJRR is to provide information to help improve the quality of care and clinical outcomes of joint replacement recipients.

CIHI captures administrative information (including diagnoses and procedure codes) and demographic information on all discharges from acute care facilities in Canada, including hip and knee joint replacements and revisions, through the Hospital Morbidity Database (HMDB). CJRR was developed to provide a rich set of additional patient, clinical, surgical and prosthesis information to complement what is captured in the HMDB, to enable more in-depth analysis of hip and knee replacements and revisions. The goal of CJRR is to provide information that is designed to help improve the quality of care and clinical outcomes of joint replacement recipients.

For more information about CJRR, visit www.cihi.ca/cjrr.

1.2 CJRR Minimum Data Set

For procedures done as of April 1, 2012, CJRR has implemented its new minimum data set (MDS) across Canada, with the release of a revised, shorter version of the data collection form and new applications for web-based and electronic file data submission. The goals of the MDS are to align CJRR data elements with the standards recommended by the International Society of Arthroplasty Registries (ISAR), reduce the burden of data collection for providers while retaining key elements required for analysis and reporting, and increase participation in the registry.

Access to procedure information is limited to data submitted in MDS format only.

1.3 Privacy and Confidentiality

As the custodian of numerous registries and databases, CIHI has stringent policies for ensuring that the privacy, confidentiality and security of its data holdings are protected. Information on CIHI's privacy and confidentiality policies and procedures is available on its website at www.cihi.ca. CJRR's privacy impact assessment is also available on the website at www.cihi.ca/cjrr.

Role-based access to the CJRR Web-Based Data Submission and Reports Tool ensures that all users are granted the appropriate level of access. Prior to use, all users of the tool must agree to the terms and conditions of use for the application, as specified on the Privacy and Confidentiality Agreement page.

1.4 Important References

These are some important references for users of the CJRR Web-Based Data Submission and Reports Tool:

- **CJRR Web-Based Data Submission and Reports Tool video demo:** available at www.cihi.ca/cjrr, under the Key Resources tab
- ***Canadian Joint Replacement Registry Manual, 2015–2016*:** available at www.cihi.ca/cjrr, under the Key Resources tab
- **CJRR web page:** www.cihi.ca/cjrr

1.5 System Overview

The CJRR Web-Based Data Submission and Reports Tool is a web-based application that

1. Allows you to submit hip and knee replacement data to CJRR online in a secure manner;
2. Provides real-time reports on a surgeon's own data; and
3. Allows you to save pre-operative data and update records post-operatively. The application is accessible 24 hours a day, 7 days a week, via CIHI's Client Services site (see Section 2.2.2, Logging in to the CJRR Application) and is available in both English and French.

When you register with CJRR, you will be assigned one of four user roles based on the level of access you require (see Section 2.1, User Roles, for more information regarding each user role). Patient information is available based on your user role. To register with CJRR, please contact Central Client Services at ccs@cihi.ca.

You can employ the web-based application to create records of patient and procedure information. When this data is saved, it undergoes a variety of quality checks. Once the mandatory data quality checks have been passed, the data is saved into the CJRR database. You also have access to various reports, in either English or French, detailing your submitted patient information and demographic and surgical statistics.

1.6 System Configuration and Registration Requirements

1.6.1 System Requirements to Access the Application

To access the CJRR Web-Based Data Submission and Reports Tool, you need a computer and live internet connection. Requirements for the operating system and internet browser are listed in Table 1.

Table 1: System Requirements to Access the CJRR Application

Requirement	Product and Version	Service Pack (if Applicable)
Operating System	Windows Vista, Windows XP, Windows 2000	Up-to-date service pack for all operating systems is recommended
Internet Browser	Internet Explorer 6.0, Internet Explorer 7.0 or higher, Firefox	N/A

The recommended computer configurations for best screen quality include the following:

- **Zoom:** 100%
- **Screen resolution:** Highest colour quality (1152 x 864 pixels)
- **Encoding:** Western European (ISO)
- **Pop-up blocker:** Enabled (turned on)

Note: CIHI strongly encourages you to use only one browser window or tab when using the CJRR Web-Based Data Submission and Reports Tool. Opening the CJRR application in multiple browsers or tabs concurrently will create system errors and may result in the loss of information.

1.6.2 Registration Requirements to Access the CJRR System

Users who wish to access the CJRR Web-Based Data Submission and Reports Tool must satisfy these requirements:

- Surgeons must be registered with CJRR; those not registered should contact CIHI by sending an email message to ccs@cihi.ca. CIHI's Central Client Services will coordinate all steps of the registration process and access set-up.
- All users must be registered with the Client Services application on CIHI's website, the access point to the CJRR system (see Section 2.2, Logon Procedures).

1.6.3 Registering Additional Users

If you are registered to use the CJRR Web-Based Data Submission and Reports Tool and would like to create additional user accounts for your office, please contact Central Client Services by sending an email to ccs@cihi.ca. If the additional user to be registered is a surgeon who is not already participating in CJRR, he or she will have to complete a registration form; please contact Central Client Services at ccs@cihi.ca to receive a registration form.

Once the additional user profile has been created, you will be contacted with details about how the new user can access the system.

1.6.4 System Availability

The CJRR Web-Based Data Submission and Reports Tool is available for use 24 hours a day, 7 days a week, with the exception of regularly scheduled maintenance and update periods.

During these periods, a message will appear on the main CJRR page notifying users that the system is undergoing maintenance. If this message is not present on your screen and the application is not functioning, please contact CIHI by sending an email to cjrr@cihi.ca.

2 Application Access

2.1 User Roles

There are four different types of user roles. Each user role has a different level of access.

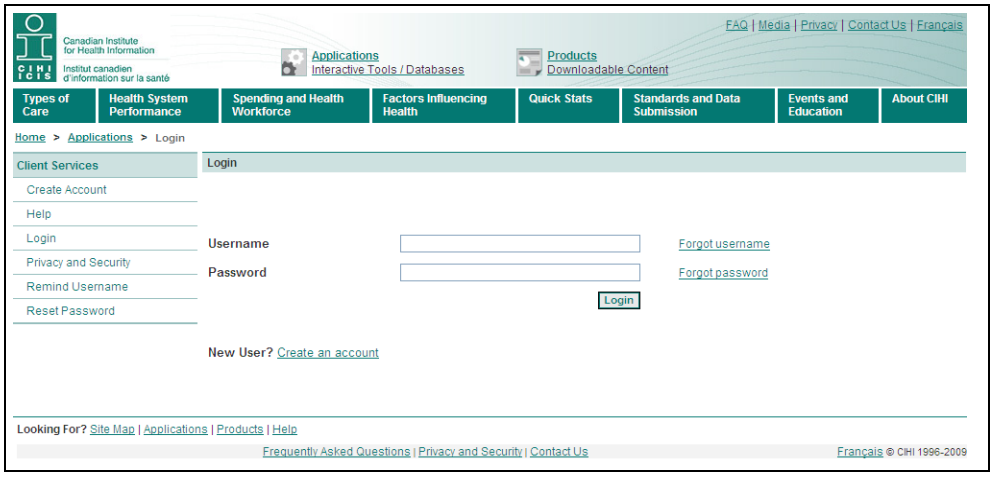
- **Facility user:** This type of user has permission to create patient information records, create and update procedure information records, run reports and download data related to procedures performed at the designated facility. Only records belonging to that facility will be accessible to this user.
- **Facility user view only:** This type of user has permission to only view patient and procedure information, run reports and download own data. This user cannot create or update patient or procedure information records. Only records belonging to a designated facility will be accessible to this user.
- **Regular user:** This type of user has permission to create patient records, create and update procedure information records, run reports and download own data for all procedures related to an associated surgeon. All records associated with the designated surgeon, regardless of facility, will be accessible to this user.
- **Reports only user:** This type of user has permission to view patient or procedure information records, run reports and download own data for all procedures related to an associated surgeon. All records associated with the designated surgeon, regardless of facility, will be accessible to this user.

2.2 Logon Procedures

2.2.1 Logging In to Client Services

To access the tool, you must log in to CIHI's website at www.cihi.ca. On CIHI's home page, click the Applications link and then click CJRR—Web-Based Data Submission. This will bring you to the Client Services Login page (see Figure 1).

Figure 1: Client Services Login Page



Enter your username and password into the appropriate fields and click Login.

After successfully logging in to the application, you will be directed to the My Services section of Client Services.

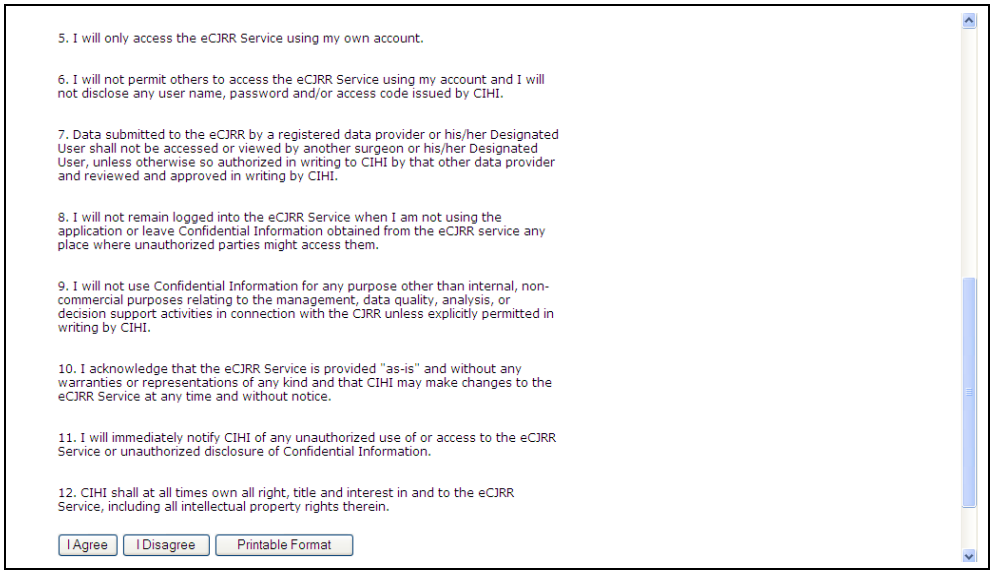
The services to which you have access will be listed on the My Services page. The service required to access the CJRR application is CJRR—Web-Based Data Submission. All CIHI services, including the CJRR Web-Based Data Submission and Reports Tool, are restricted and require permission from CIHI. Please send an email to CIHI at ccs@cihi.ca to obtain access to CJRR's web-based system.

2.2.2 Logging In to the CJRR Application

Upon clicking CJRR—Web-Based Data Submission on the My Services page, you will be directed to the Privacy and Confidentiality Agreement page.

Please read through the privacy and confidentiality agreement to ensure you understand it (see Figure 2).

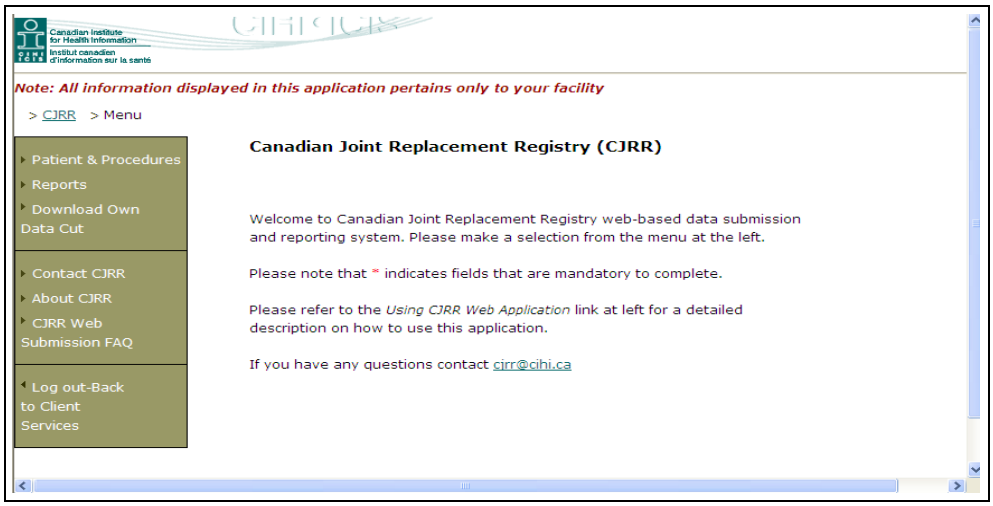
Figure 2: Privacy and Confidentiality Agreement Page


5. I will only access the eCJRR Service using my own account.
6. I will not permit others to access the eCJRR Service using my account and I will not disclose any user name, password and/or access code issued by CIHI.
7. Data submitted to the eCJRR by a registered data provider or his/her Designated User shall not be accessed or viewed by another surgeon or his/her Designated User, unless otherwise so authorized in writing to CIHI by that other data provider and reviewed and approved in writing by CIHI.
8. I will not remain logged into the eCJRR Service when I am not using the application or leave Confidential Information obtained from the eCJRR service any place where unauthorized parties might access them.
9. I will not use Confidential Information for any purpose other than internal, non-commercial purposes relating to the management, data quality, analysis, or decision support activities in connection with the CJRR unless explicitly permitted in writing by CIHI.
10. I acknowledge that the eCJRR Service is provided "as-is" and without any warranties or representations of any kind and that CIHI may make changes to the eCJRR Service at any time and without notice.
11. I will immediately notify CIHI of any unauthorized use of or access to the eCJRR Service or unauthorized disclosure of Confidential Information.
12. CIHI shall at all times own all right, title and interest in and to the eCJRR Service, including all intellectual property rights therein.
I Agree
I Disagree
Printable Format

Click I Agree only if you understand and concur with the agreement.

- Click I Agree to be forwarded to the main CJRR welcome page (see Figure 3).
- Click I Disagree if you are not in agreement with the privacy and confidentiality terms and conditions; you will be redirected to the My Services page.
- Click Printable Format to print a hard copy of the agreement.

Figure 3: CJRR Welcome Page


Canadian Institute for Health Information
Institut canadien d'information sur la santé
Note: All information displayed in this application pertains only to your facility
> CJRR > Menu
Patient & Procedures
Reports
Download Own Data Cut
Contact CJRR
About CJRR
CJRR Web Submission FAQ
Log out-Back to Client Services
Canadian Joint Replacement Registry (CJRR)
Welcome to Canadian Joint Replacement Registry web-based data submission and reporting system. Please make a selection from the menu at the left.
Please note that * indicates fields that are mandatory to complete.
Please refer to the Using CJRR Web Application link at left for a detailed description on how to use this application.
If you have any questions contact cjrr@cihi.ca

2.2.3 Logging Out of the CJRR Application

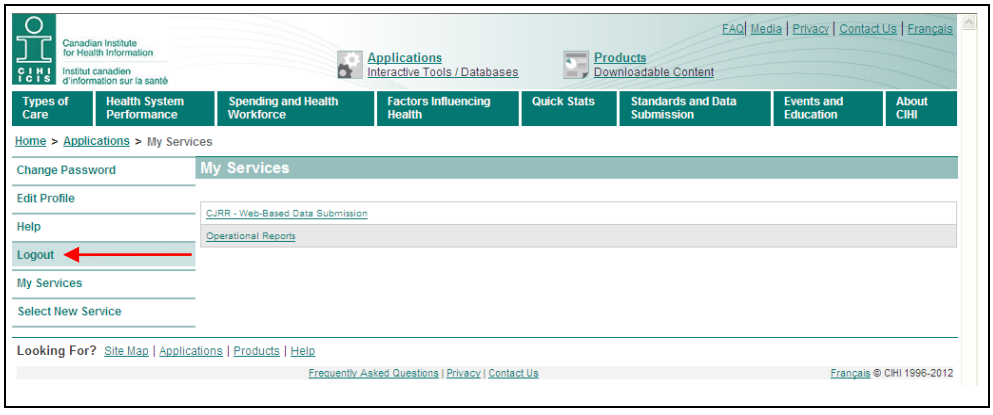
You may exit the application and return to the My Services page from any location in the application. Before exiting the application, make sure you save any new or updated information.

Note: The CJRR application will automatically log you out if it is idle for five minutes or more.

To exit the CJRR application, click Log out—Back to Client Services in the menu to the left of the page.

This will bring you to the My Services page, where you must click Logout from the menu on the left side of the page to log out of Client Services (see Figure 4).

Figure 4: Logging Out of Client Services



Note: You must properly log out of *both* the CJRR application *and* Client Services to maintain privacy of the data. Please do not close your browser window without logging out of both the CJRR application and Client Services.

3 Entering Information Into the System

3.1 Patient Information

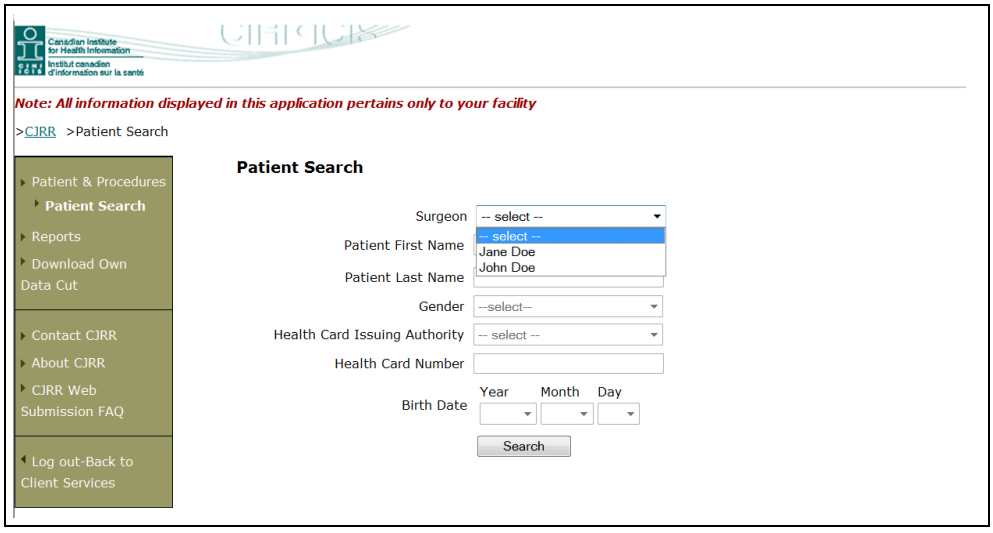
3.1.1 Searching for Patients

All users must first conduct a patient search to ensure the patient does not already exist for the given surgeon before doing any of the following:

- Creating a record for a new patient;
- Reviewing records for an existing patient;
- Creating a record for a new procedure for a patient; and
- Updating/viewing records for an existing procedure.

To begin a patient search, click Patient & Procedures on the left side of the page to see the submenu. From the submenu, click Patient Search. This will forward you to the Patient Search page (see Figure 5).

Figure 5: Patient Search Page



Note: Each patient search is based on the associated surgeon. You may search only for patients who are associated with the surgeon whose records you have permission to access.

Three steps are involved in conducting a patient search:

Step 1: Identify the surgeon who performed the patient's procedure.

- Users with permissions for one surgeon: The surgeon's name will be displayed in the Surgeon field.
- Users with permissions for multiple surgeons: Select the appropriate surgeon name from the drop-down menu.

Step 2: Conduct a patient search by entering search criteria.

- Complete any or all of the fields to find the patient. When you click Search, the relevant search results will be displayed.
- Users may leave the patient search fields blank. When you click Search, a list of all of the surgeon's patients will be displayed.

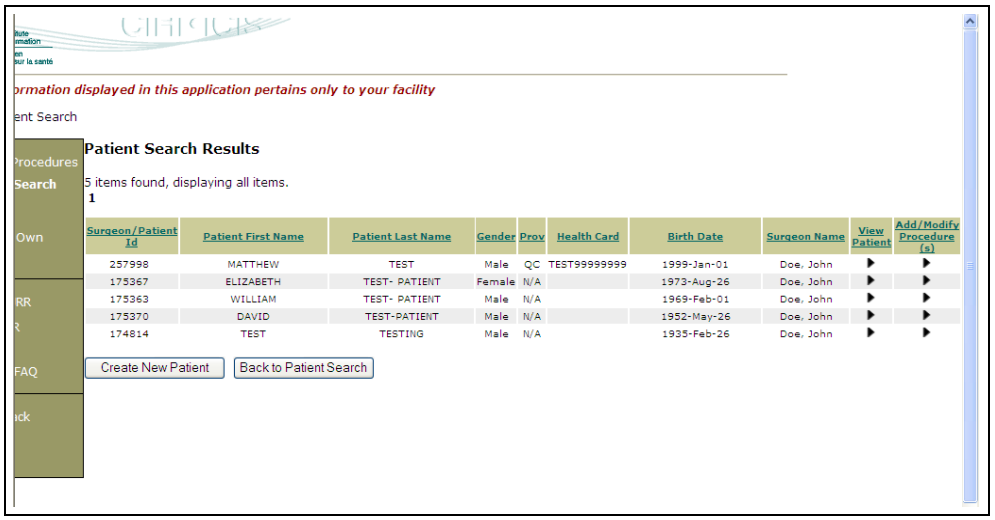
Note for users assigned to multiple surgeons: If you complete all patient information fields and subsequently change the surgeon's name, all patient information will be cleared and must be entered again.

Step 3: Click Search.

If all the search fields have been completed correctly, any patients matching the search criteria for the specified surgeon will be displayed.

The Patient Search Results page contains a patient information bar for each patient found in the search (see Figure 6).

Figure 6: Patient Search Results Page



The patient information bar provides a quick view of the requested patient. The following columns are provided for each patient record:

- **Surgeon/Patient ID:** The patient number assigned by the system.
- **Patient First Name and Patient Last Name:** The patient's given name and surname.
- **Gender:** The patient's gender.
- **Province:** The province that issued the patient's health card.
- **Health Card:** The patient's health card number.
- **Birth Date:** The patient's date of birth.

- **Surgeon Name:** The name of the patient's surgeon.
- **View Patient:** A link to the Patient Data page, where you can view the patient's information.
- **Add/Modify Procedure(s):** A link to the Procedure History for Patient page, where you can create and update information on the patient's procedure.

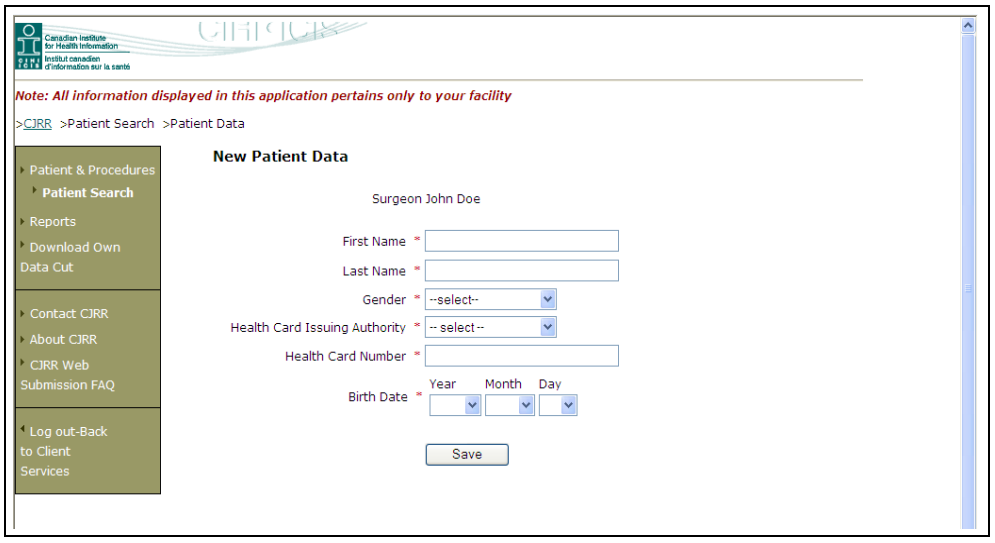
If there is no match for the search criteria, you will be directed to a page where you can either begin another search or create a new patient record.

3.1.2 Creating a New Patient

Facility and regular users can create new patient records associated with the surgeon who conducted the procedure. New patient records may be created after a patient search confirms that the patient does not exist (see Section 3.1.1, Searching for Patients). When this occurs, the Patient Search Results page will give you two options:

- Click Back to Patient Search if you are sure the patient exists or if there was an error in your patient search fields. Selecting this option will return you to the Patient Search page.
- Click Create New Patient to create records for a new patient for a given surgeon. This will bring you to the New Patient Data page (see Figure 7).

Figure 7: New Patient Data Page


Canadian Institute for Health Information
Institut canadien d'information sur la santé
Note: All information displayed in this application pertains only to your facility
>CJRR >Patient Search >Patient Data
Patient & Procedures
Patient Search
Reports
Download Own Data Cut
Contact CJRR
About CJRR
CJRR Web Submission FAQ
Log out-Back to Client Services
New Patient Data
Surgeon John Doe
First Name *
Last Name *
Gender * --select--
Health Card Issuing Authority * -- select --
Health Card Number *
Birth Date * Year Month Day
Save

On the New Patient Data page (Figure 7), red asterisks (*) denote the fields that must be filled in when you create a new patient record. These mandatory fields are the following:

- **First Name*:** Enter the patient's given name. This must be a minimum of 2 characters and a maximum of 25 characters.
- **Last Name*:** Enter the patient's surname. This must be a minimum of 2 characters and a maximum of 25 characters.
- **Gender*:** Select male, female or other from the drop-down menu.

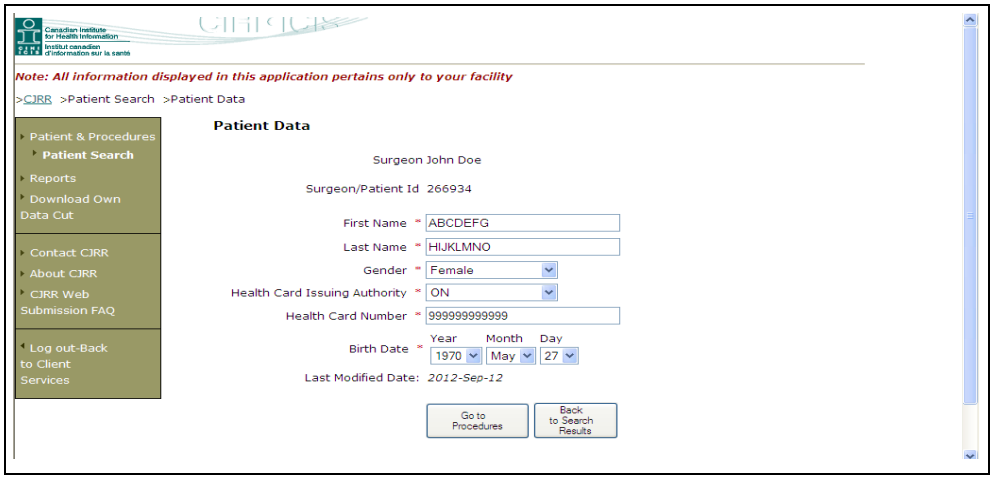
- **Health Card Issuing Authority*:** From the drop-down menu, select the province that issued the health card. If you select N/A, do not fill in the Health Card Number field; if you do, an error message will appear prompting you to remove the information. N/A should be selected **only** in cases where the health card number is not known (that is, the patient does not have a health card number).
- **Health Card Number*:** This field is mandatory when a valid Health Card Issuing Authority is selected. It is an essential field in the CJRR database to allow for functions such as following patients over time. The health card number will be validated when you click Save health card number is invalid, an error message will appear.
- **Birth Date*:** Select the year, month and day of the patient's date of birth from the drop-down menus.

Note: If any of these fields are incomplete or not completed correctly, an error message pertaining to the relevant field will appear at the top of the screen. The records will not be saved until **all** errors related to mandatory fields are corrected.

Once you have correctly completed the mandatory fields on this page, click Save to save the new patient record in the database.

Once the information has been saved, the Patient Data page will appear (Figure 8).

Figure 8: Patient Data Page


Canadian Institute for Health Information
Institut canadien d'information sur la santé
Note: All information displayed in this application pertains only to your facility
>CJRR >Patient Search >Patient Data
Patient & Procedures
Patient Search
Reports
Download Own Data Cut
Contact CJRR
About CJRR
CJRR Web Submission FAQ
Log out-Back to Client Services
Patient Data
Surgeon John Doe
Surgeon/Patient Id 266934
First Name * ABCDEFG
Last Name * HIJKLMNO
Gender * Female
Health Card Issuing Authority * ON
Health Card Number * 999999999999
Birth Date * Year 1970 Month May Day 27
Last Modified Date: 2012-Sep-12
Go to Procedures
Back to Search Results

There are two buttons at the bottom of the Patient Data page:

Go to Procedures

Go to Procedures: Click this button to create and modify information for the procedures associated with the chosen patient and relevant surgeon. Clicking this button will forward you to the Procedure History for Patient page.

Back to Search Results

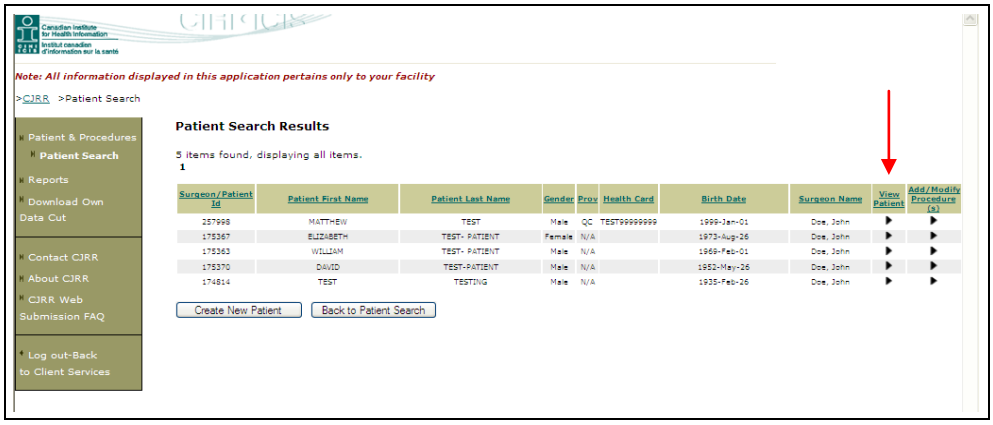
Back to Search Results: Click this button to return to the Search Results page.

3.1.3 Correcting/Deleting Patient Information

If any existing patient information needs to be corrected or deleted, you must contact CJRR. **Do not send personal health information via email or fax.**

To review records for an existing patient, perform a search for the patient. This will bring you to the Patient Search Results page (see Figure 9). The steps to follow to conduct a patient search are outlined in Section 3.1.1, Searching for Patients.

Figure 9: Patient Search Results Page


Note: All information displayed in this application pertains only to your facility
>CJRR >Patient Search
Patient & Procedures
Patient Search
Reports
Download Own Data Cut
Contact CJRR
About CJRR
CJRR Web Submission FAQ
Log out-Back to Client Services
Patient Search Results
5 items found, displaying all items.
Surgeon/Patient Id
Patient First Name
Patient Last Name
Gender
Prov
Health Card
Birth Date
Surgeon Name
View Patient
Add/Modify Procedure (s)
157998 MATTHEW TEST Male QC TEST99999999 1999-Jan-01 Doe, John
175367 ELIZABETH TEST- PATIENT Female N/A 1973-Aug-26 Doe, John
175363 WILLIAM TEST- PATIENT Male N/A 1969-Feb-01 Doe, John
175370 DAVID TEST-PATIENT Male N/A 1952-May-26 Doe, John
174814 TEST TESTING Male N/A 1935-Feb-26 Doe, John
Create New Patient
Back to Patient Search

To view a patient profile, click View Patient (see Figure 9).

3.2 Procedure Information

3.2.1 Creating Joint Procedure Records

Facility and regular users can create and update a patient's procedure record.

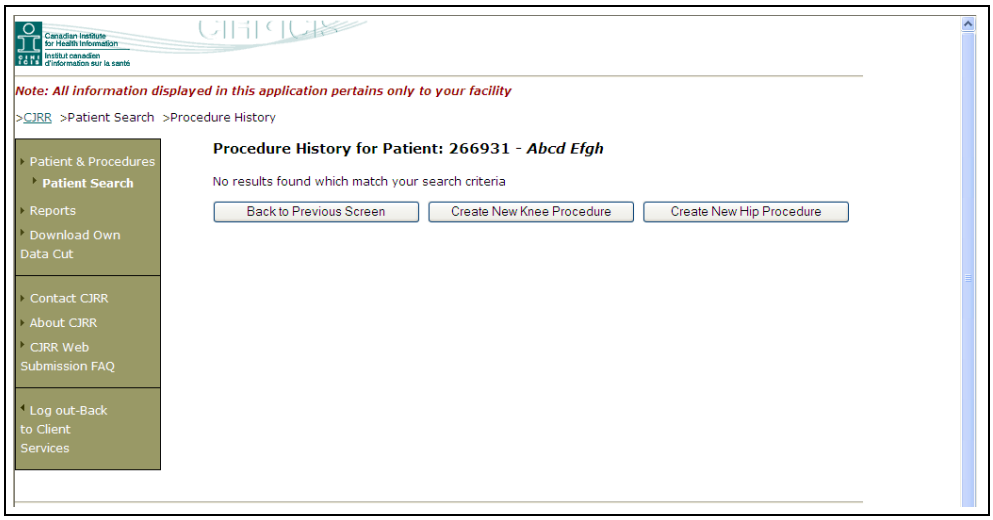
To create a record for a patient's hip or knee procedure, the patient must already exist for that surgeon; otherwise, a new patient record must be created.

Creating a New Procedure for a Patient Who Already Exists

Note: Only those procedures submitted in the minimum data set format will be displayed on the Procedure History for Patient page. Facility users will be permitted to access procedures that pertain to their own facility only.

- Begin by searching for your patient (see Section 3.1.1, Searching for Patients).
- You will be forwarded to the Patient Search Results page that lists patients for a particular surgeon.
- Click the Add/Modify Procedure(s) arrow for the required patient.
- This will forward you to the Procedure History for Patient page.
- Click the appropriate button (either Create New Hip Procedure or Create New Knee Procedure) to create the new procedure record (see Figure 10).

Figure 10: Procedure History for Patient Page


Canadian Institute for Health Information
Institut canadien d'information sur la santé
Note: All information displayed in this application pertains only to your facility
>CJRR >Patient Search >Procedure History
Patient & Procedures
Patient Search
Reports
Download Own Data Cut
Contact CJRR
About CJRR
CJRR Web Submission FAQ
Log out-Back to Client Services
Procedure History for Patient: 266931 - Abcd Efgh
No results found which match your search criteria
Back to Previous Screen
Create New Knee Procedure
Create New Hip Procedure

Creating a Procedure for a New Patient

- Create a record for a new patient (see Section 3.1.2, Creating a New Patient).
- Once this is done, you will be forwarded to the Patient Data page.
- On the Patient Data page, click Go to Procedures.
- You will be forwarded to the Procedure History for Patient page (see Figure 10).
- Click the appropriate button (either Create New Knee Procedure or Create New Hip Procedure) to create the new procedure.

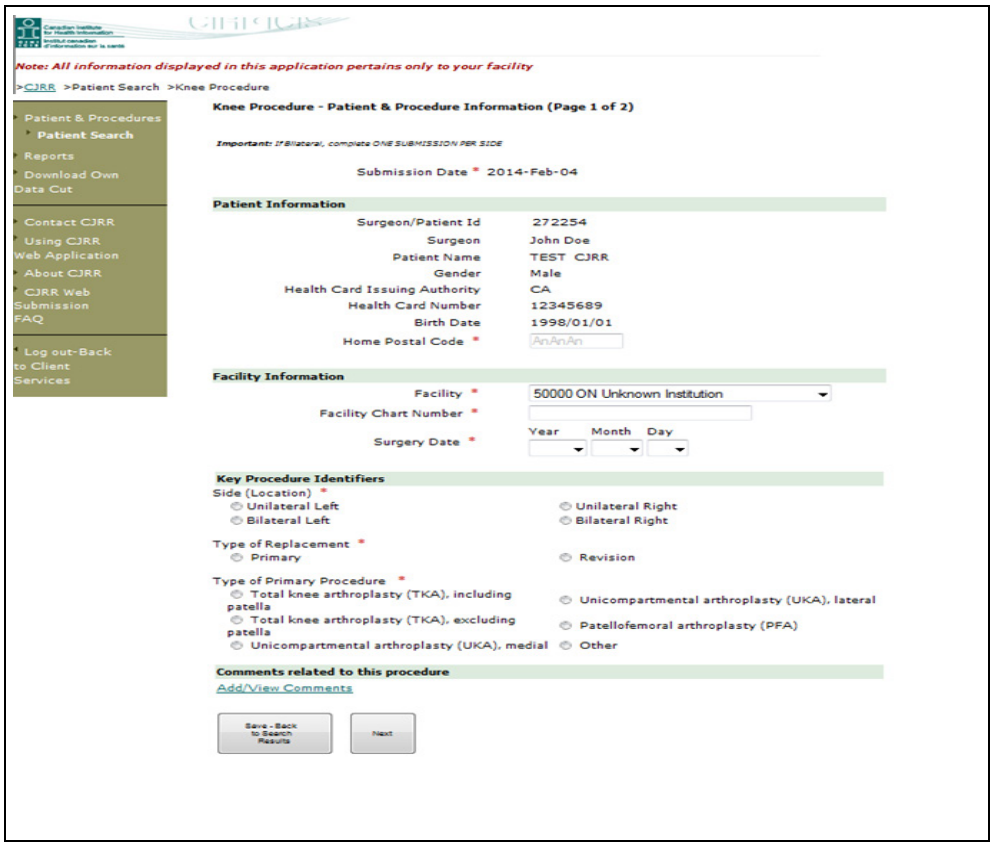
3.2.2 Creating a New Hip or Knee Procedure Record

This section outlines the steps for creating a hip or knee procedure record. Please note that the steps for creating hip and knee procedure records are similar, although specific fields may vary.

Hip/Knee Procedure—Patient & Procedure Information (Page 1 of 2)

From the Procedure History for Patient page, click Create New Hip Procedure to create a hip procedure record or Create New Knee Procedure to create a knee procedure record. This will bring you to the Patient & Procedure Information (Page 1 of 2) page for the type of procedure (hip or knee) selected (see Figure 11). This is the first of two pages that must be completed. (**Note: All fields are mandatory.**)

Figure 11: Patient & Procedure Information (Page 1 of 2)



Page 1 is divided into four sections, which are described below. At the very top of the page is the **Submission Date***, which displays the current date and cannot be changed.

Patient Information

This section displays the patient's demographic data, which cannot be updated on this page. If any patient information needs to be corrected, you must contact CJRR to request the correction. Do not send personal health information by email or fax.

Home Postal Code*: This is a mandatory field. The patient's valid Canadian postal code must be entered in the format A1A1A1, with no spaces. For patients who do not reside in Canada, enter Z9Z9Z9. The postal code will be validated against the province that issued the health card before you continue to the next page.

Facility Information

The fields in this section are the following:

- **Facility*:** This is a mandatory field. If you are a facility user, the facility will appear by default.

  Select the facility where the surgery was performed from the drop-down menu of Canadian facilities. The facility chosen may or may not be the surgeon's primary facility. Facilities are sorted by institution number.

- **Facility Chart Number*:** This is a mandatory field. The patient's chart number is the one on the chart in the facility where the surgery was performed (also known as Hospital Chart Number).

Note: Health Card Number is not permitted in Chart Number field. For instances where Chart Number is not available or Health Card Number is included in the Chart Number, enter "UNKNOWN."

- **Surgery Date*:** This is a mandatory field. Choose the year, month and date from the drop-down menus to form a valid date that is not later than the current date.

Key Procedure Identifiers

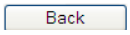
The fields in this section are the following:

- **Side (Location)*:** This is a mandatory field, and only one option can be selected. This field represents the side on which the procedure was performed.
- **Type of Replacement*:**
  - Selecting Primary will disable the Reason for Revision option on page 2.
  - Selecting Revision will disable the Diagnostic Grouping section on page 2.
- **Type of Primary Procedure*:** This is a mandatory field only if Type of Replacement is Primary. This selection determines which component stickers need to be completed.

Comments Related to This Procedure

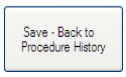
This section allows you to add or view comments regarding the joint replacement. Clicking Add/View Comments will forward you to the Comments page.

The Comments page is optional and allows you to make additional comments of up to 1,000 characters pertaining to the hip or knee procedure. The Comments page is available from each page of the procedure record; comments are added cumulatively from one page to the next.

Once you have added comments, click 

to return to the first page of the procedure information record.

At the bottom of the page, the following buttons are used to save the partially completed record or to continue to the next page:

- Click 

to save only page 1. This action will validate the data on page 1 before returning to the procedure history. If mandatory fields are missing, you must complete them before returning to the Procedure History for Patient page.

  This partially saved procedure can be updated at a future date (for example, once the patient's procedure has been completed). Once the data has been saved, the page will return to the patient's procedure history.

- Click to save the data entered on page 1 and continue to the second Patient & Procedure Information page. This action will validate the data on page 1 before continuing to page 2. If any mandatory fields are missing, they must be completed before continuing to page 2.

Error Messages for Mandatory Fields

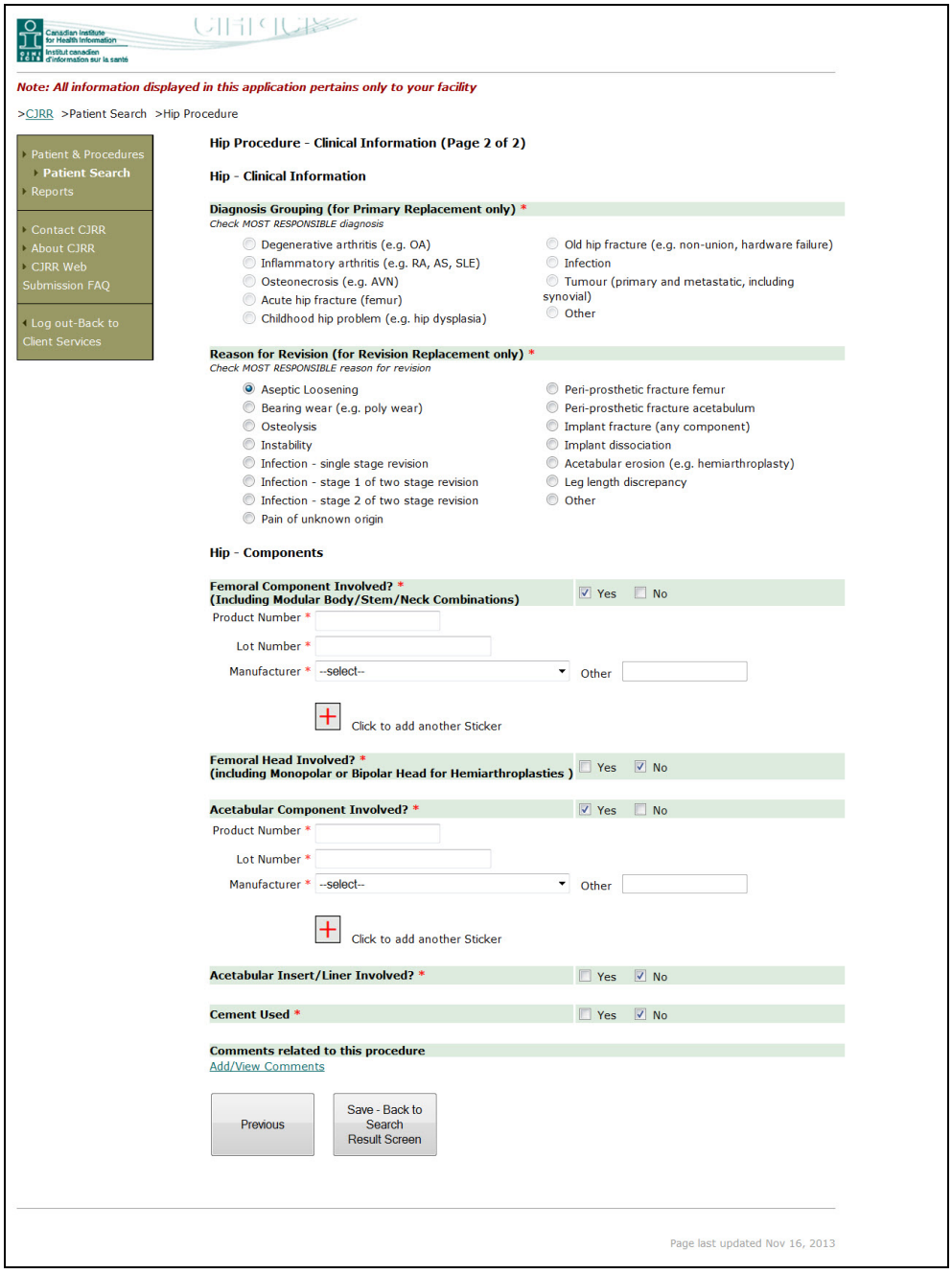
If any of the mandatory fields are incomplete or invalid when you save the record, error messages will appear at the top of the page describing the error, and the relevant fields will be highlighted in red. You must correct these errors to continue to the subsequent page.

The record will be successfully saved only if all mandatory fields are completed accurately.

Hip or Knee Procedure—Clinical Information (Page 2 of 2)

Upon successfully completing the first page, you will be forwarded to the Hip Procedure—Clinical Information page (see Figure 12) or the Knee Procedure—Clinical Information page (see Figure 13).

Figure 12: Hip Procedure—Clinical Information (Page 2 of 2)


Canadian Institute for Health Information
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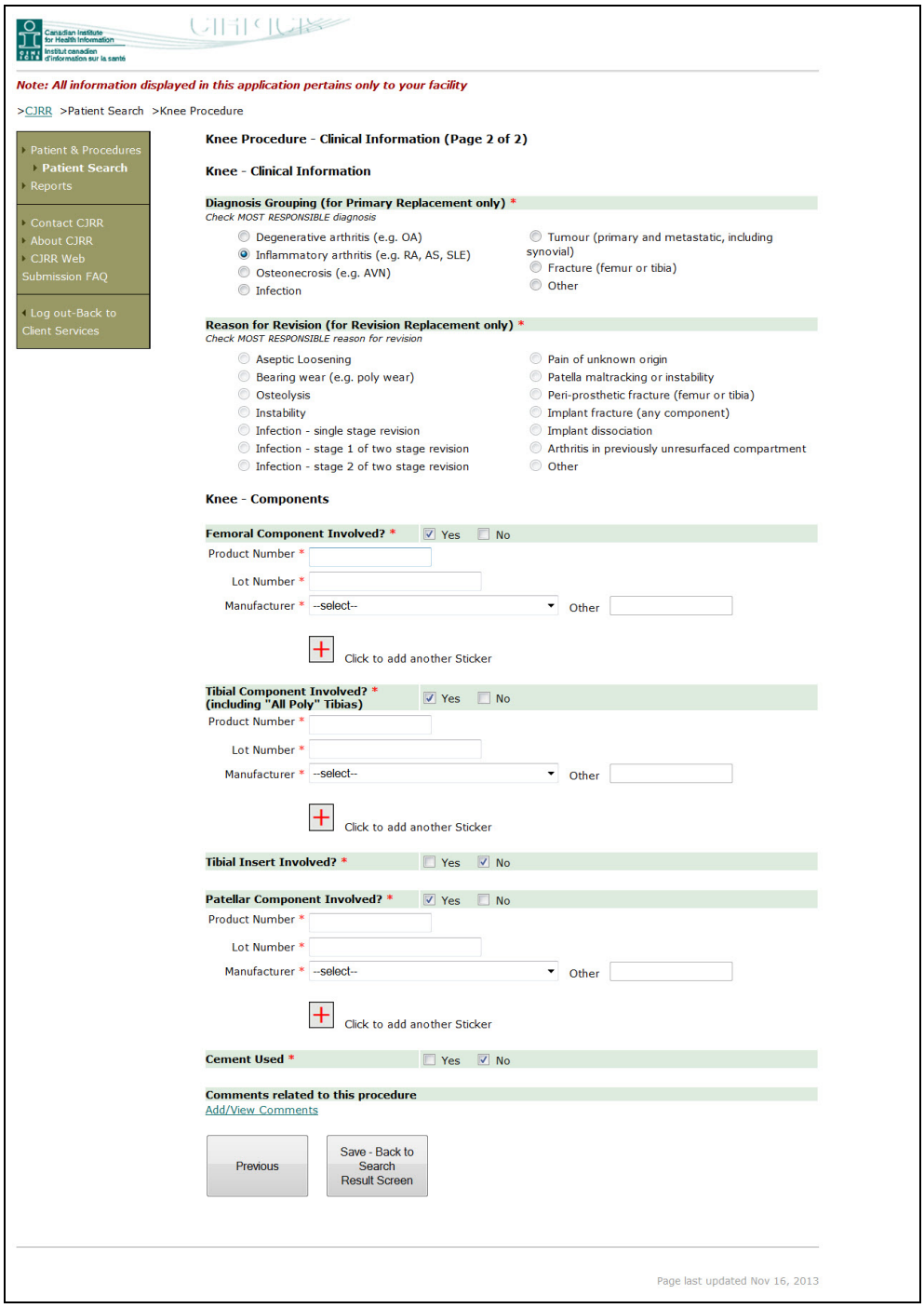
Note: All information displayed in this application pertains only to your facility
>CJRR >Patient Search >Hip Procedure
Patient & Procedures
Patient Search
Reports
Contact CJRR
About CJRR
CJRR Web Submission FAQ
Log out-Back to Client Services
Hip Procedure - Clinical Information (Page 2 of 2)
Hip - Clinical Information
Diagnosis Grouping (for Primary Replacement only) *
Check MOST RESPONSIBLE diagnosis
Degenerative arthritis (e.g. OA)
Inflammatory arthritis (e.g. RA, AS, SLE)
Osteonecrosis (e.g. AVN)
Acute hip fracture (femur)
Childhood hip problem (e.g. hip dysplasia)
Old hip fracture (e.g. non-union, hardware failure)
Infection
Tumour (primary and metastatic, including synovial)
Other
Reason for Revision (for Revision Replacement only) *
Check MOST RESPONSIBLE reason for revision
Aseptic Loosening
Bearing wear (e.g. poly wear)
Osteolysis
Instability
Infection - single stage revision
Infection - stage 1 of two stage revision
Infection - stage 2 of two stage revision
Pain of unknown origin
Peri-prosthetic fracture femur
Peri-prosthetic fracture acetabulum
Implant fracture (any component)
Implant dissociation
Acetabular erosion (e.g. hemiarthroplasty)
Leg length discrepancy
Other
Hip - Components
Femoral Component Involved? * (Including Modular Body/Stem/Neck Combinations)
Yes No
Product Number *
Lot Number *
Manufacturer * --select-- Other
Click to add another Sticker
Femoral Head Involved? * (including Monopolar or Bipolar Head for Hemiarthroplasties)
Yes No
Acetabular Component Involved? *
Yes No
Product Number *
Lot Number *
Manufacturer * --select-- Other
Click to add another Sticker
Acetabular Insert/Liner Involved? *
Yes No
Cement Used *
Yes No
Comments related to this procedure
Add/View Comments
Previous
Save - Back to Search Result Screen
Page last updated Nov 16, 2013

Figure 13: Knee Procedure—Clinical Information (Page 2 of 2)


Canadian Institute for Health Information
Institut canadien d'information sur la santé
Note: All information displayed in this application pertains only to your facility
>CJRR >Patient Search >Knee Procedure
Patient & Procedures
Patient Search
Reports
Contact CJRR
About CJRR
CJRR Web Submission FAQ
Log out-Back to Client Services
Knee Procedure - Clinical Information (Page 2 of 2)
Knee - Clinical Information
Diagnosis Grouping (for Primary Replacement only) *
Check MOST RESPONSIBLE diagnosis
Degenerative arthritis (e.g. OA)
Inflammatory arthritis (e.g. RA, AS, SLE)
Osteonecrosis (e.g. AVN)
Infection
Tumour (primary and metastatic, including synovial)
Fracture (femur or tibia)
Other
Reason for Revision (for Revision Replacement only) *
Check MOST RESPONSIBLE reason for revision
Aseptic Loosening
Bearing wear (e.g. poly wear)
Osteolysis
Instability
Infection - single stage revision
Infection - stage 1 of two stage revision
Infection - stage 2 of two stage revision
Pain of unknown origin
Patella maltracking or instability
Peri-prosthetic fracture (femur or tibia)
Implant fracture (any component)
Implant dissociation
Arthritis in previously unresurfaced compartment
Other
Knee - Components
Femoral Component Involved? * Yes No
Product Number *
Lot Number *
Manufacturer * --select-- Other
Click to add another Sticker
Tibial Component Involved? * (including "All Poly" Tibias) Yes No
Product Number *
Lot Number *
Manufacturer * --select-- Other
Click to add another Sticker
Tibial Insert Involved? * Yes No
Patellar Component Involved? * Yes No
Product Number *
Lot Number *
Manufacturer * --select-- Other
Click to add another Sticker
Cement Used * Yes No
Comments related to this procedure
Add/View Comments
Previous
Save - Back to Search Result Screen
Page last updated Nov 16, 2013

Diagnosis Grouping (for Primary Replacement Only)

This section describes the most responsible diagnosis for surgery and is mandatory only if the Type of Replacement (on page 1) is Primary. If the Type of Replacement is Revision, this field will be disabled.

If the Type of Replacement is Primary, select the most appropriate diagnosis from the radio buttons provided. Only one button may be selected.

Reason for Revision (for Revision Replacement Only)

This section describes the most responsible reason for revising the original surgery and is mandatory only if the Type of Replacement (on page 1) is Revision. If the Type of Replacement is Primary, this field will be disabled.

If the Type of Replacement is Revision, select the most appropriate reason for revision from the radio buttons provided. Only one button may be selected.

Hip/Knee—Components

This section provides information on the components that were implanted. The selections available will be enabled or disabled based on your previous selections for Type of Replacement or Type of Primary Procedure. You may add up to three implant stickers for each component, except Cement Used, where you may add up to two stickers only. Click to add an additional sticker to a component.

- **Catalogue/Reference Number*:** Enter the catalogue number of the replacement part used. This field has a maximum length of 60 alphabetical/numerical characters.
- **Lot Number*:** Enter the lot number of the replacement part used. This field has a maximum length of 90 characters.
- **Manufacturer*:** Select the part manufacturer from the drop-down menu. If the manufacturer is not listed, select Other and, in the field provided, enter the name of the manufacturer. This field has a maximum length of 60 alphabetical/numerical characters.
- **Cement Name*:** Select the name of the cement used from the drop-down menu. Select the most appropriate option. If the cement used is not listed, select Other and, in the field provided, enter the cement name. This field has a maximum length of 60 alphabetical/numerical characters.

Note: As of April 2013, the CJRR electronic file submission and Web-Based Data Submission and Reports Tool systems were modified to accept product and lot numbers for implant components and cement that have been scanned directly from barcodes. The CJRR system is still able to accept manually entered implant information when scanning barcodes is not an option. Refer to Appendix A for detailed instructions for both methods of data entry.

3.2.3 Updating/Deleting an Existing Hip or Knee Procedure Record

Updating an Existing Hip or Knee Procedure Record

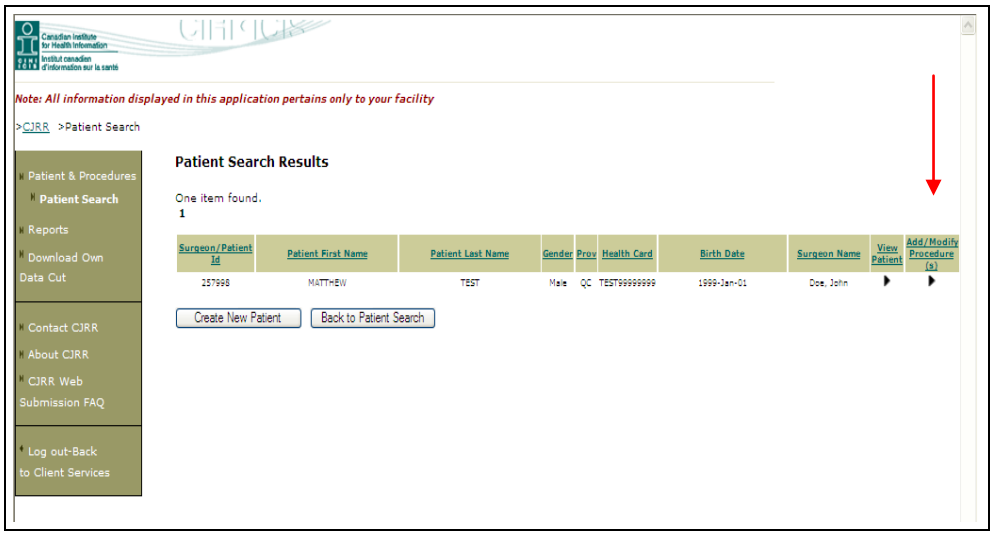
Facility and regular users have permission to update a patient's existing procedure information.

Step 1: Perform Patient Search

First, you must perform a search for the patient whose procedure will be updated (see Section 3.1.1, Searching for Patients).

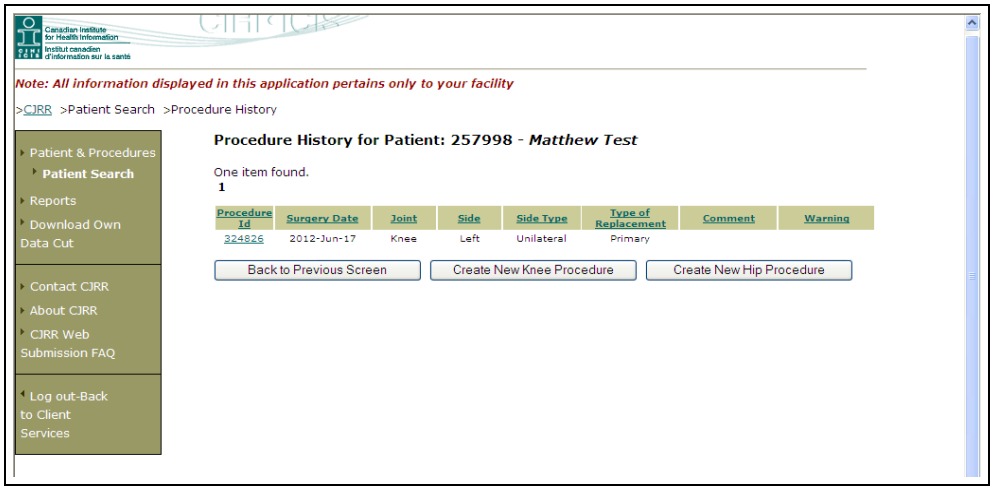
On the Patient Search Results page, click the Add/Modify Procedure(s) arrow (see Figure 14).

Figure 14: Patient Search Results Page



This will bring you to the Procedure History for Patient page (see Figure 15).

Figure 15: Procedure History for Patient Page



Step 2: Select the Procedure

Click the Procedure ID for the relevant procedure to be updated. You will be forwarded to the first Patient & Procedure Information page (see Figure 16).

Figure 16: Patient & Procedure Information (Page 1 of 2)

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>CJRR >Patient Search >Knee Procedure
Patient & Procedures
Patient Search
Reports
Download Own Data Cut
Contact CJRR
About CJRR
CJRR Web Submission FAQ
Log out-Back to Client Services
Knee Procedure - Patient & Procedure Information (Page 1 of 2)
Procedure Id: 324860
Important: If Bilateral, complete ONE SUBMISSION PER SIDE
Submission Date * 2012-Aug-02
Last Modified Date: 2012-Sep-11
Patient Information
Surgeon/Patient Id 258028
Surgeon John Doe
Patient Name abcd abcs
Gender Male
Health Card Issuing Authority QC
Health Card Number zzzz99999999
Birth Date 1999/01/01
Home Postal Code * M9M9M9
Facility Information
Facility ON Unknown Institution

You can access the second Patient & Procedure Information page by clicking the Next button. Make the required changes on the relevant procedure page(s) and save the procedure on page 2 by clicking Save—Back to Search Result Page.

Deleting a Hip or Knee Procedure Record

To delete a procedure record, please contact CJRR at cjrr@cihi.ca.

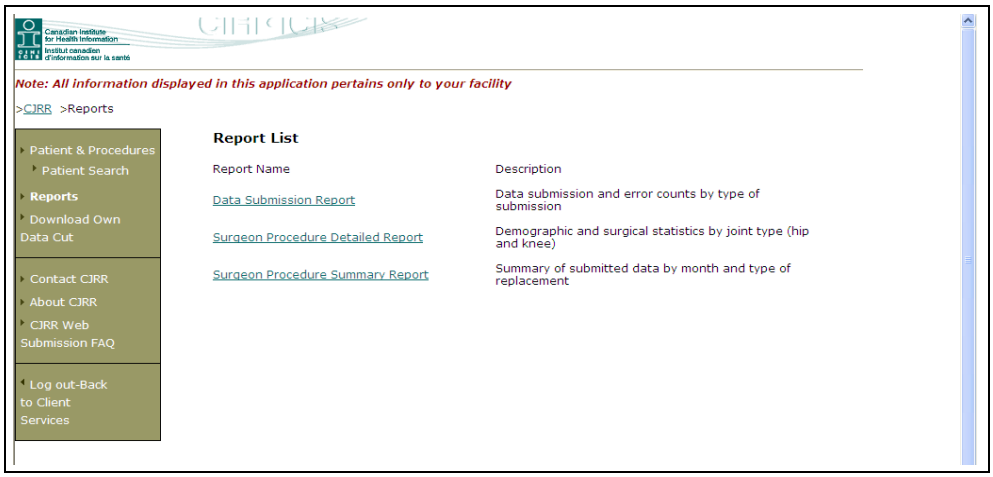
4 Reports

Facility user, facility user view only and regular users are permitted to access the Reports section of the tool.

Note: All reports are available in PDF format. Only data submitted in the minimum data set format will be shown.

Click Reports from the left side menu of the main welcome page. This will bring you to the Report List page (see Figure 17).

Figure 17: Report List Page


Canadian Institute for Health Information
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Note: All information displayed in this application pertains only to your facility
>CJRR >Reports
Patient & Procedures
Patient Search
Reports
Download Own Data Cut
Contact CJRR
About CJRR
CJRR Web Submission FAQ
Log out-Back to Client Services
Report List
Report Name
Description
Data Submission Report
Data submission and error counts by type of submission
Surgeon Procedure Detailed Report
Demographic and surgical statistics by joint type (hip and knee)
Surgeon Procedure Summary Report
Summary of submitted data by month and type of replacement

The Report List page allows you to view reports regarding your surgeon's data and to print them in PDF format. By clicking the hyperlinked report name, you may view and print three types of reports, which are described in the following sections.

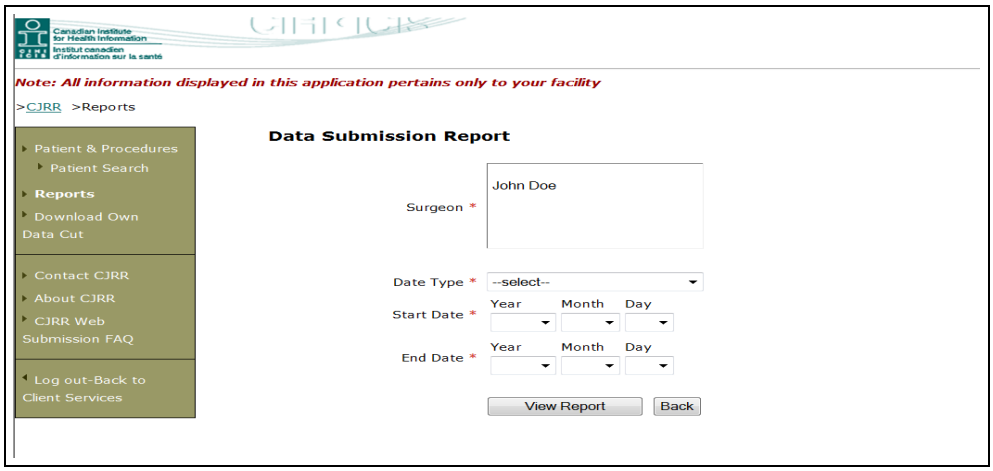
4.1 Data Submission Report

The Data Submission Report provides details on data submitted to CJRR, by surgeon. This report is based on a specified date range.

To view or print this report, click Data Submission Report on the Report List page.

This will forward you to the Data Submission Report page (see Figure 18).

Figure 18: Data Submission Report Page



On the Data Submission Report page, complete the mandatory fields to view the report.

The mandatory fields are the following:

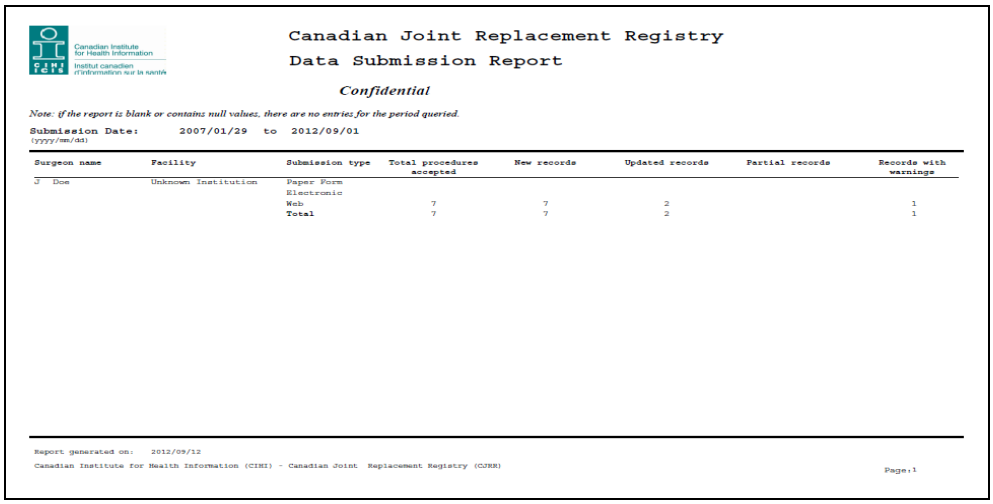
- **Surgeon*:** Select the appropriate surgeon. If you have access to multiple surgeons, you may view their reports in one combined report. To do this, press the Shift and End keys to select all of the surgeons in the Surgeon field. You may select a maximum of 20 surgeons at a time.
- **Date Type*:** Use the drop-down menu to select the type of date the report will be based on. The surgery date is the actual date the surgery took place and the submission date is when a procedure record was created in the CJRR system.
- **Start Date*** and **End Date*:** Select the start and end dates for the required report. The end date must be later than the start date. The start date must be within the previous five years.

Note: To view the Data Submission Report, please disable your pop-up blocker.

Click View Report to generate the report based on the criteria entered. If any of the fields in the report request page are incomplete, an error message will appear at the top of the page prompting you to complete the fields.

Figure 19 displays a sample Data Submission Report for one surgeon.

Figure 19: Sample Data Submission Report



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Canadian Joint Replacement Registry
Data Submission Report

Confidential

Note: if the report is blank or contains null values, there are no entries for the period queried.

Submission Date: 2007/01/29 to 2012/09/01
(yyyy/mm/dd)

Surgeon name	Facility	Submission type	Total procedures accepted	New records	Updated records	Partial records	Records with warnings
J Doe	Unknown Institution	Paper Form					
		Electronic					
		Web	7	7	2		1
		Total	7	7	2		1

Report generated on: 2012/09/12
Canadian Institute for Health Information (CIHI) - Canadian Joint Replacement Registry (CJRR)
Page:1

The Data Submission Report summarizes the data that each surgeon contributed to the CJRR application and by which method the data was submitted—electronic, paper or web. All information in the report is presented separately by submission type.

The report has the following columns:

- **Surgeon Name:** Name of the surgeon who submitted patient information.
- **Facility:** Facility where the patient's procedure was performed.
- **Submission Type:** The medium by which the data was submitted.
- **Total Procedures Accepted:** The number of procedures submitted with all the mandatory fields correctly completed.
- **New Records:** The number of new records that were submitted within the selected date range.
- **Updated Records:** The number of records that were updated within the selected date range.
- **Partial Records:** The number of procedure records that have only the first page completed (if entered using the web tool), meaning the record is partially completed.
- **Records With Warnings:** The number of records that were saved with warnings. Warnings indicate that optional fields were left blank.

4.2 Surgeon's Procedure Detailed Report

The Surgeon's Procedure Detailed Report provides a summary of certain key elements relating to hip and knee procedures performed by the selected surgeon during the date range specified.

To view or print this report, click Surgeon Procedure Detailed Report on the Report List page.

This will forward you to the Surgeon Procedure Detailed Report page, as illustrated in Figure 20.

Figure 20: Surgeon Procedure Detailed Report Page

Complete the mandatory fields to view the report. These are the following:

- **Surgeon*:** Select the appropriate surgeon. If you have access to multiple surgeons, you may view their reports in one combined report. To do this, press the Shift and End keys to select all the surgeons in the Surgeon field. You may select a maximum of 20 surgeons at a time.
- **Date Type*:** This drop-down menu allows you to select the type of date the report will be based on. The surgery date is the actual date the surgery took place and the submission date is when a procedure record was created in the CJRR system.
- **Start Date*** and **End Date*:** These fields indicate the start and end dates for the required report date range. The end date must be later than the start date.
- **Joint Type*:** Indicates which joint to view the report by: hip, knee or both.

Note: To view the Surgeon's Detailed Procedure Report, please disable your pop-up blocker.

Click View Report to generate the report based on the criteria entered.

If any of the fields in the report request page are blank, an error message will appear at the top of the page prompting you to complete the fields. If there are no errors, a second window will appear with the PDF report.

Figure 21 displays a portion of a sample Surgeon's Procedure Detailed Report for hip replacements.

Figure 21: Sample Surgeon's Procedure Detailed Report

Canadian Joint Replacement Registry
Surgeon's Procedure Detailed Report
Confidential

Submission Date: 2007/01/01 to 2012/09/01
(yyyy/mm/dd)
Note: if the report is blank or contains null values, there are no entries for the period queried.

Surgeon Name: John Doe

Hip Procedures

Elements	Values	Total	% of Group total
Sex	Male	4	100%
	Female	0	0%
	Other	0	0%
Age	<45	3	75%
	45 - 54	0	0%
	55 - 64	0	0%
	65 - 74	0	0%
	75 - 84	1	25%
	>85	0	0%
Side (Location)	Unilateral Right	0	0%
	Unilateral Left	4	100%
	Bilateral Right	0	0%
	Bilateral Left	0	0%
Type of Replacement	Primary	1	25%
	Revision	3	75%
Type of Primary Procedure	Total Hip Arthroplasty	0	0%
	Resurfacing	0	0%
	Monopolar/Unipolar Hemiarthroplasty	1	100%
	Bipolar Hemiarthroplasty	0	0%
	Other	0	0%
Diagnosis Grouping	Degenerative arthritis (e.g. OA)	0	0%
	Inflammatory arthritis (e.g. RA, AS, SLE)	0	0%
	Osteonecrosis (e.g. AVN)	1	100%
	Acute hip fracture (femur)	0	0%

Report generated on: 2012/09/12
Canadian Institute for Health Information (CIHI) - Canadian Joint Replacement Registry (CJRR)

Each page of the report contains four columns of information. These are the following:

- **Elements:** Includes patient and procedure information, further portioned into values.
- **Values:** Divides the Elements column into more descriptive and precise components of patient/procedure information.
- **Total:** Provides the total counts per value.
- **% of Group Total:** Provides the percentage based on the element's total.

If the report is generated for more than one surgeon, a summary page will be provided at the end of the report.

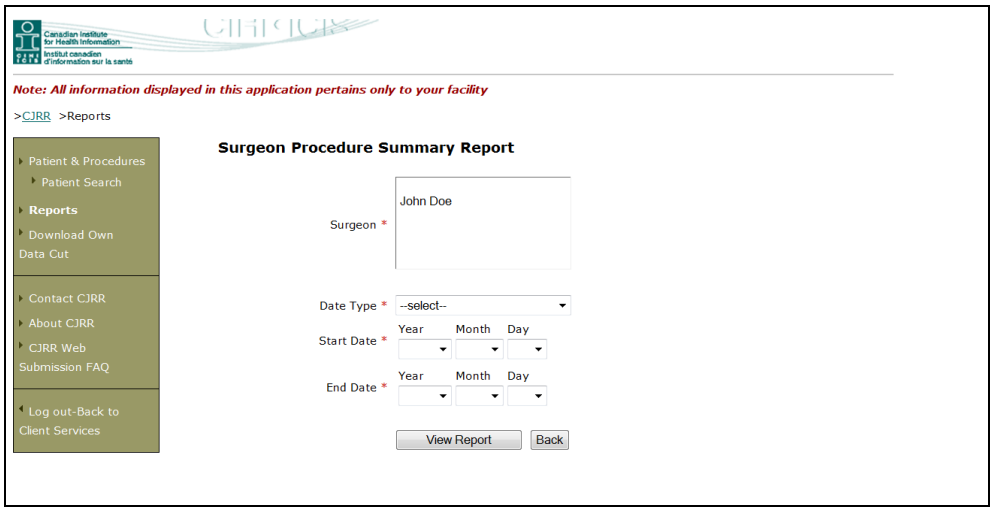
4.3 Surgeon's Procedure Summary Report

The Surgeon's Procedure Summary Report summarizes patient/procedure information submitted by each surgeon. The report is based on a specified date range and displays the total procedures by the type of surgery and joint type.

To view or print this report, click Surgeon Procedure Summary Report on the Report List page.

This will forward you to the Surgeon Procedure Summary Report page (see Figure 22).

Figure 22: Surgeon Procedure Summary Report Page



On the Surgeon Procedure Summary Report page, complete the mandatory fields to view the report. These are the following:

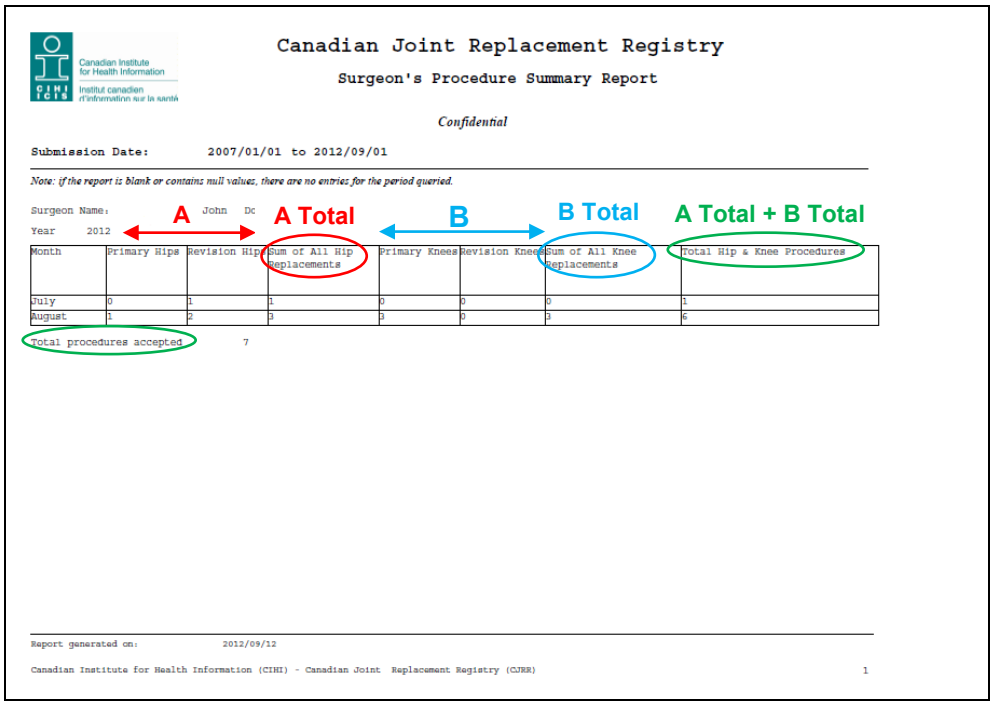
- **Surgeon*:** Select the appropriate surgeon. If you have access to multiple surgeons you may view their reports in one combined report. To do this, press the Shift and End keys to select the surgeons you wish to view in the Surgeon field. You may select a maximum of 20 surgeons at a time.
- **Date Type*:** This drop-down menu allows you to select the type of date the report will be based on. The surgery date is the actual date the surgery took place and the submission date is when a procedure record was created in the CJRR system.
- **Start Date*** and **End Date*:** These fields indicate the start and end dates for the required report date range. The end date must be later than the start date.

Note: To view the Surgeon's Detailed Procedure Report, please disable your pop-up blocker.

Click View Report to generate the report based on the criteria entered.

If any of the fields in the report request page are left blank, an error message will appear at the top of the page prompting you to complete the fields. If there are no errors, a second window will appear with the PDF report.

Figure 23: Sample Surgeon's Procedure Summary Report



Canadian Joint Replacement Registry

Surgeon's Procedure Summary Report

Confidential

Submission Date: 2007/01/01 to 2012/09/01

Note: if the report is blank or contains null values, there are no entries for the period queried.

Surgeon Name: John Dc

Year 2012

A A Total B B Total A Total + B Total

Month	Primary Hips	Revision Hips	Sum of All Hip Replacements	Primary Knees	Revision Knees	Sum of All Knee Replacements	Total Hip & Knee Procedures
July	0	1	1	0	0	0	1
August	1	2	3	3	0	3	6

Total procedures accepted 7

Report generated on: 2012/09/12

Canadian Institute for Health Information (CIHI) - Canadian Joint Replacement Registry (CJRR) 1

The Surgeon's Procedure Summary Report is displayed in a tabular format and provides monthly summaries on types of joint replacement procedures over a selected date range (see Figure 23).

The report displays a monthly summary of hip and knee procedures, broken down by type of procedure (number of primary, revision and excision procedures) and joint type. An overall total of all procedures (hip and knee) is produced at the end of the report.

- **A—Hip replacements:** The two types of hip replacement columns recorded on a monthly basis are denoted by A. The sum of all hip replacements in a given month is tallied in the Sum of All Hip Replacements column, A Total.
- **B—Knee replacements:** The two types of knee replacement columns recorded on a monthly basis are denoted by B. The sum of all knee replacements in a given month is tallied in the Sum of All Knee Replacements column, B Total.
- **Total—Hip and knee procedures:** The total of all hip and knee procedures for a given month of a given year is tallied in the Total Hip & Knee Procedures column, A Total + B Total. At the bottom of the table, the row "Total procedures accepted" tallies the total of all the replacements for the dates requested.

5 Download Own Data Cut

The CJRR Own Data Cut feature of the CJRR Web-Based Data Submission and Reports Tool allows authorized users to download data that a surgeon provided to CJRR.

To download a surgeon's own data, click Download Own Data Cut from the menu on the left side of the main welcome page.

5.1 Accessing the Report: Obtaining the Appropriate Authorization

Clicking Download Own Data Cut will forward you directly to the Own Data Cut Report page. If you are not yet authorized to run this report, a message will appear to that effect (see Figure 24).

Figure 24: Own Data Cut Report—Not Yet Authorized Message Page

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Note: All information displayed in this application pertains only to your facility
>CJRR >Reports
Patient & Procedures
Patient Search
Reports
Download Own Data Cut
Contact CJRR
Using CJRR Web Application
About CJRR
CJRR Web Submission FAQ
Log out-Back to Client Services
Own Data Cut Report
The CJRR Own Data Cut feature of the CJRR Web-Based Data Submission and Reports Tool allows a designated user with the appropriate permissions to download data that a surgeon or hospital has provided to CJRR. The data is provided in a comma delimited format (CSV), which the user can import to other tools (such as Excel, SAS, and so forth) for further analysis.
Currently you do not have access to this feature. To request access to this feature, please contact cjrr@cihi.ca and a representative of CJRR will then contact you to initiate the process.
Page last updated Nov 16, 2013

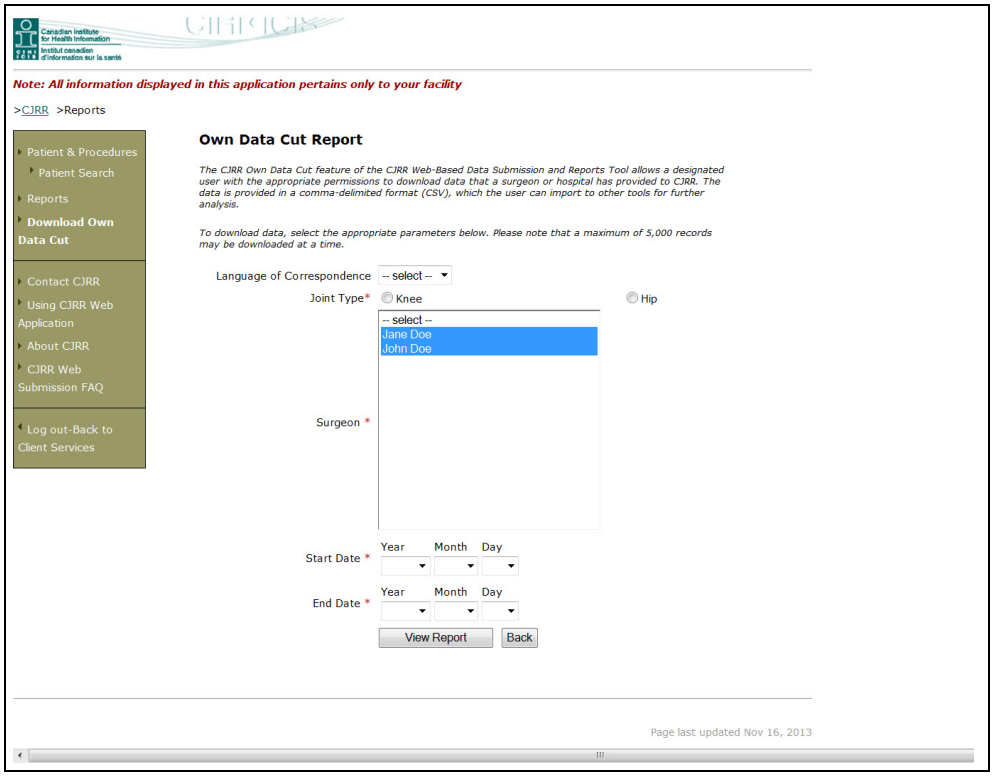
To request access to the Own Data Cut Report, click on the email address in the second paragraph of the message. An automated email will be sent to cjrr@cihi.ca requesting that you be granted access to the report. Please be sure to include the name of the surgeon that requires access.

Your request will be processed by CIHI staff. Please allow at least one week for your request to be processed.

5.2 Accessing the Report: Once Authorization Is Granted

Clicking Download Own Data Cut will forward you directly to the Own Data Cut Report page, where you can select the criteria for generating the report (see Figure 25).

Figure 25: Own Data Cut Report Page


Canadian Institute for Health Information
Institut canadien d'information sur la santé
Note: All information displayed in this application pertains only to your facility
>CJRR >Reports
Patient & Procedures
Patient Search
Reports
Download Own Data Cut
Contact CJRR
Using CJRR Web Application
About CJRR
CJRR Web Submission FAQ
Log out-Back to Client Services
Own Data Cut Report
The CJRR Own Data Cut feature of the CJRR Web-Based Data Submission and Reports Tool allows a designated user with the appropriate permissions to download data that a surgeon or hospital has provided to CJRR. The data is provided in a comma-delimited format (CSV), which the user can import to other tools for further analysis.
To download data, select the appropriate parameters below. Please note that a maximum of 5,000 records may be downloaded at a time.
Language of Correspondence
-- select --
Joint Type*
Knee
Hip
-- select --
Jane Doe
John Doe
Surgeon *
Start Date *
Year
Month
Day
End Date *
View Report
Back
Page last updated Nov 16, 2013

On the Own Data Cut Report page, complete the mandatory fields to view the report.

The mandatory fields are the following:

- **Joint Type*:** Select the joint to generate the data cut by: hip or knee. The column headings in the report will vary based on the type of joint selected.
- **Surgeon*:** Select the appropriate surgeon. If you have access to multiple surgeons, you may generate their data cuts in one combined report. To do this, press the Shift and End keys to select all the surgeons in the Surgeon field.
- **Start Date*** and **End Date*:** The start and end dates represent surgery dates. Select the initial and final surgery dates for the required data cut. The end date must be later than the start date. The start date must be within the previous five years.

Note: To view the Own Data Cut Report, please disable your pop-up blocker.

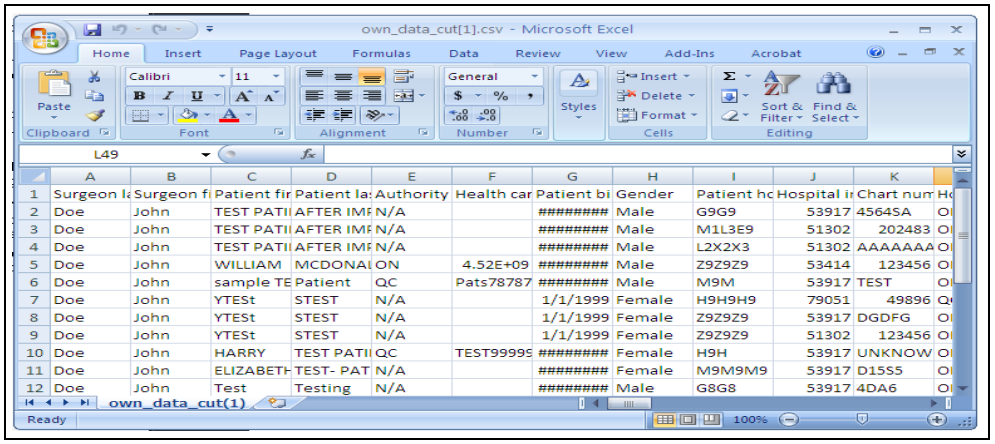
Click View Report to generate the report based on the criteria entered.

The report will be produced in a comma-separated value (CSV) format and can be viewed or saved to your computer. Note that a maximum of 5,000 records may be downloaded per data cut.

If any of the mandatory fields in the report request page are incomplete, an error message will appear at the top of the page prompting you to complete the fields. If there are no errors, a second window will appear with the CSV report.

Figure 26 displays a portion of a sample Own Data Cut Report for a knee replacement.

Figure 26: Sample Own Data Cut Report



	A	B	C	D	E	F	G	H	I	J	K
1	Surgeon la	Surgeon fi	Patient fir	Patient la:	Authority	Health car	Patient bi	Gender	Patient hc	Hospital ir	Chart num
2	Doe	John	TEST PATI	AFTER IMI	N/A		########	Male	G9G9	53917	4564SA
3	Doe	John	TEST PATI	AFTER IMI	N/A		########	Male	M1L3E9	51302	202483
4	Doe	John	TEST PATI	AFTER IMI	N/A		########	Male	L2X2X3	51302	AAAAAAA
5	Doe	John	WILLIAM	MCDONAL	ON	4.52E+09	########	Male	Z9Z9Z9	53414	123456
6	Doe	John	sample TE	Patient	QC	Pats78787	########	Male	M9M	53917	TEST
7	Doe	John	YTESt	STEST	N/A		1/1/1999	Female	H9H9H9	79051	49896
8	Doe	John	YTESt	STEST	N/A		1/1/1999	Female	Z9Z9Z9	53917	DGDFG
9	Doe	John	YTESt	STEST	N/A		1/1/1999	Female	Z9Z9Z9	51302	123456
10	Doe	John	HARRY	TEST PATI	QC	TEST99999	########	Female	H9H	53917	UNKNOW
11	Doe	John	ELIZABETH	TEST- PAT	N/A		########	Female	M9M9M9	53917	D15S5
12	Doe	John	Test	Testing	N/A		########	Male	G8G8	53917	4DA6

Note: The information shown in the above figure is fictitious and is for demonstration purposes only. No real data is shown.

This report provides a listing of the surgeon's raw data on all patient and procedure records. The report is sorted by the surgeon's last name.

6 Validations, Error Messages and Warnings

6.1 Validations

Validations are data quality checks that are carried out on all the fields on a particular page to identify incomplete or inconsistent data in an effort to reduce the amount of erroneous information saved in the database. These checks are triggered when you press the Save button or when you navigate from one page to the next.

A variety of checks are carried out to identify invalid data:

- **Data quality checks on invalid characters:** This type of validity check is performed on all free-text fields where information is entered. Certain characters (for example, <, >, #, *, /, %, { and }) are invalid and cannot be entered into the application. They produce an error and prevent the record from being saved in the database.

- **Data quality checks for inconsistent data:** This type of validity check is performed in all related fields where the value in one field determines the acceptable values in a related field. Other checks include values that fall outside of acceptable ranges. Examples of these validity checks include, but are not limited to, the following:
  - **Postal Code related to Province:** The Postal Code field and the Province field are validated together to ensure that the patient's postal code is in his or her home province.
  - **Health Card Number related to Health Card Issuing Authority:** The Health Card Number field and Health Card Issuing Authority field are validated together to ensure that the patient's health card number belongs to the correct health card issuing authority.
  - **Patient Age:** Patient cannot be younger than 13 or older than 130.

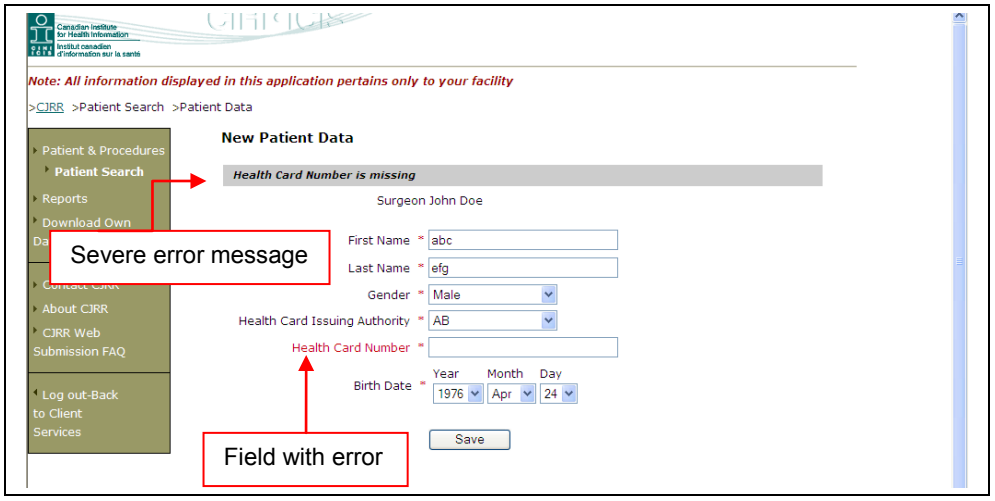
6.2 Error Messages and Warnings

Error messages are generated when invalid or inconsistent data is entered into a particular field. The messages serve as a visual warning to alert you to take corrective action.

Error messages are presented to you in two ways:

1) **Severe error messages:** These messages are highlighted in grey and appear at the top of the page. In addition, the field with the error is highlighted in red (see Figure 27). *Note that the term "severe error" refers to an error that must be resolved before a record can be saved.*

Figure 27: Example of Severe Error Message



Once a severe error is generated, you will not be allowed to save or continue to the next page until all fields with severe errors have been entered correctly.

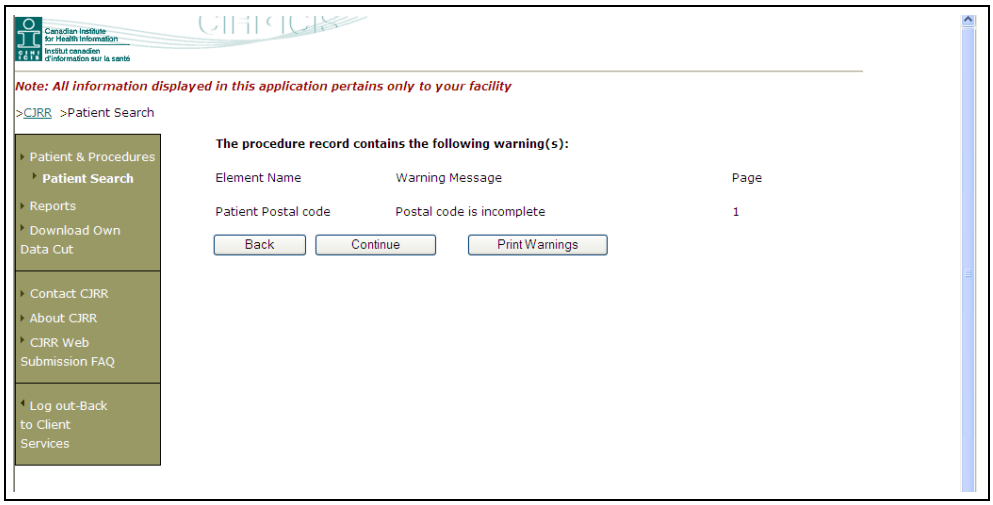
Severe error messages occur when

- A mandatory field is left blank;
- Invalid information is selected or entered; and
- Invalid characters are entered into a field.

Note: A severe error message at the top of the page when a search is being performed or when information is being saved indicates that the information entered was not saved, the search was not conducted or both.

2) **Warning page for Home Postal Code:** A warning message is generated to alert you to an incomplete (half-entered) Home Postal Code (for example, M9M). This message appears in a separate window in the hip or knee procedure pages (see Figure 28). The partially entered postal code will save; however, the warning notifies you of this non-severe error to help improve the quality of the data submitted and ultimately to help improve information reported from the database.

Figure 28: Postal Code Warning Message



The Warning page tells you that the postal code is incomplete. A short description of the error and the reference page are provided.

The Warning page presents you with three options:

Back

Click this button to return to the previous page to edit the postal code.

Continue

Click this button to ignore the warnings and continue to the next page of the hip or knee information record.

Print Warnings

Click this button to print the warnings to your default printer.

7 Support

For registration and access inquiries, please contact Central Client Services at ccs@cihi.ca.

If you have any questions or comments about the CJRR Web-Based Data Submission and Reports Tool, please contact CJRR by sending an email to cjrr@cihi.ca.

If you would like to learn more about CJRR or inquire about requesting data from CJRR, please visit CJRR's web page at www.cihi.ca/cjrr.

For all other inquiries, please contact CJRR at cjrr@cihi.ca.

Appendix—Entering Prosthesis and Cement Information

Data submitters are provided with two options when entering product or cement information: barcode scanning and manual entry. This appendix presents instructions for both methods of entry along with samples of fictitious product labels based on actual manufacturer stickers. Note that this is not an exhaustive list and is intended for demonstration purposes only.

If you notice any discrepancies or new sticker variations, please inform CJRR by email at cjrr@cihi.ca.

The following guidelines apply to the entry of implant sticker information (for manual entry of data, skip to Step 3C):

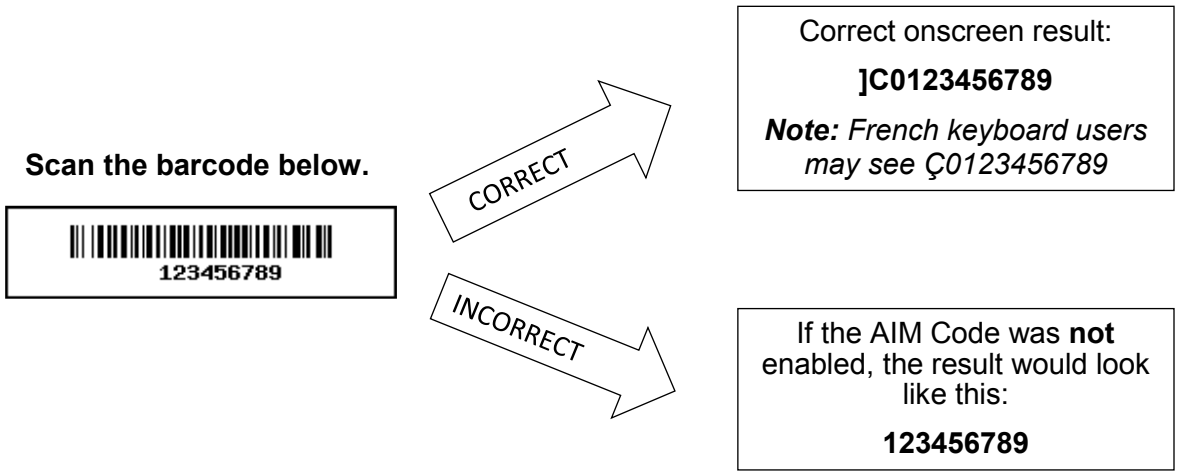
Step 1: Setting Up a Barcode Scanner

The first step is **to enable transmission of the Automatic Identification and Mobility (AIM) Code**. Refer to the scanner's user manual for more information. Scanner settings are often enabled or disabled by scanning special barcodes provided in the user manual.

Enabling the AIM Code is necessary for the CJRR internal system to recognize the entry as a scanned barcode rather than a manually entered value. Without the AIM Code, the CJRR system will not trigger the extraction of a clean product and lot number.

Note: If the AIM Code is not enabled, the CJRR system will not extract the product and lot numbers from the scanned value.

Step 2: Verifying That the AIM Code Transmission Is Enabled

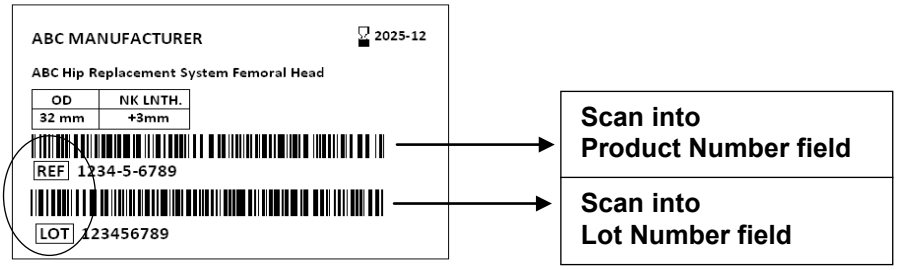


Step 3: Scanning Barcodes

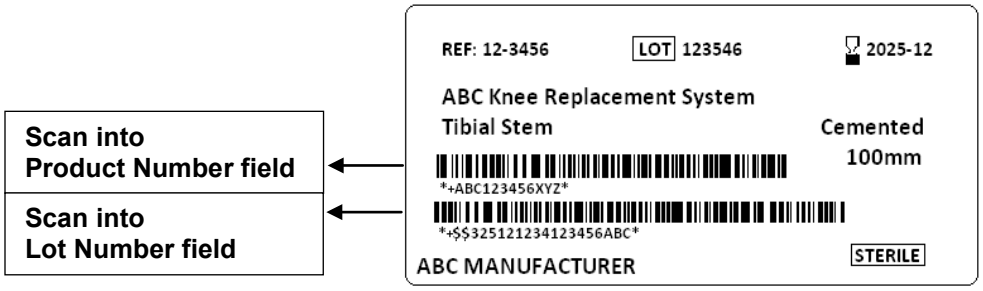
- With the AIM Code enabled, each scanned barcode should lead with a square bracket (“]”). If this is missing, it may be an indication that the AIM Code was not enabled. (See Step 1.)
  - French keyboard users: In place of the leading], scanned output will lead with a cedilla (either “¸” or “Ç”).
- **The Three General Categories of Product Label Appearance**

A. Implant Stickers With Two Barcodes

1. Is this a product sticker from the manufacturer Link?
   - For Link products, do not scan the barcode. The product and lot numbers need to be manually entered (exactly as they appear on the sticker).
   - If not, proceed.
2. Does the sticker identify the product or lot number under each barcode?
   - If so, scan the applicable barcodes into the Product Number and Lot Number fields.

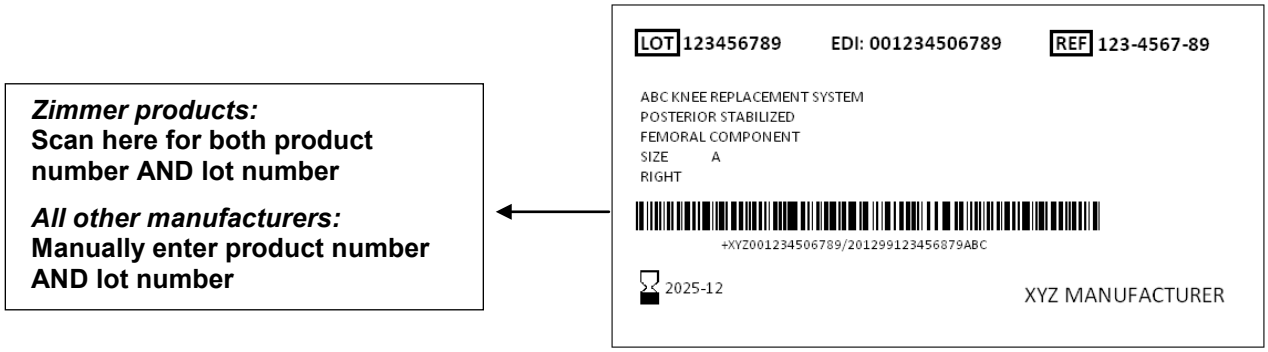


   - If not, scan the top barcode into the Product Number field and the bottom barcode into the Lot Number field.



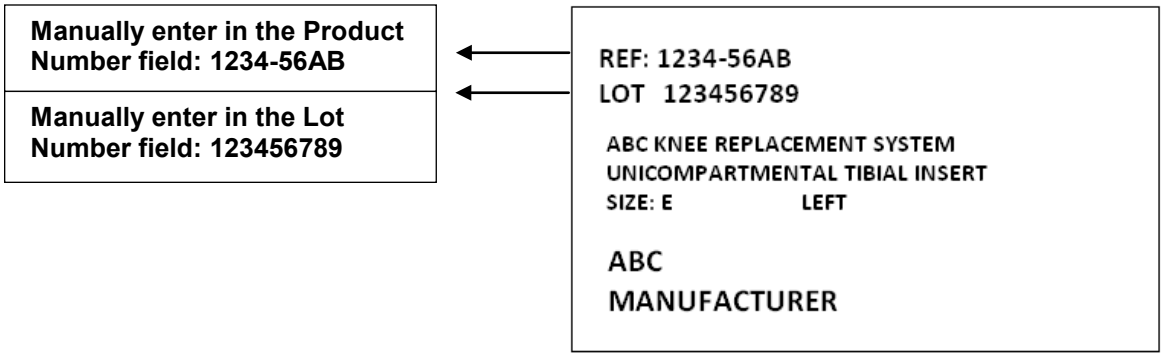
B. Implant Stickers With One Barcode

1. Is this a product sticker from the manufacturer Zimmer?
   - For Zimmer products (with only one barcode), scan the same barcode into both the Product Number and Lot Number fields.
   - For all other manufacturers, **manually enter** the catalogue/reference number in the Product Number field and the lot number in the Lot Number field.

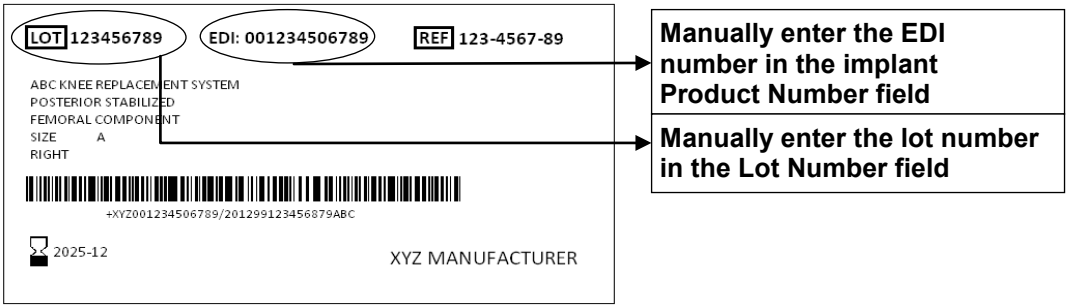


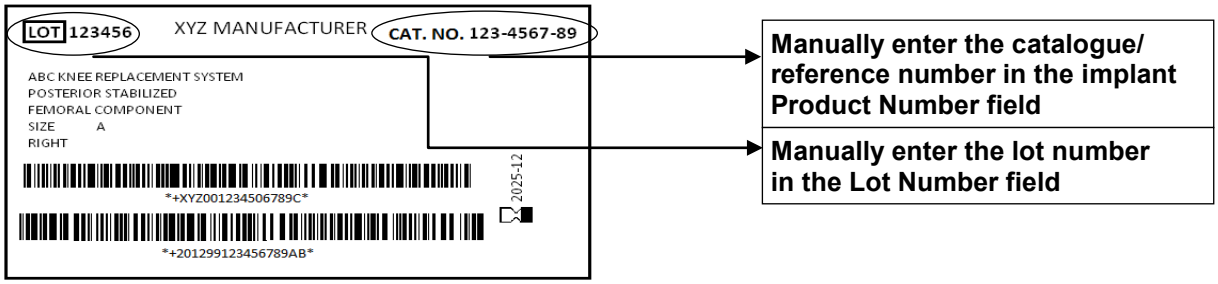
C. Implant Stickers Without a Barcode or Manual Entry Option

- Enter the catalogue/reference number in the Product Number field and the lot number in the Lot Number field.
- All information should be entered exactly as it appears on the sticker.



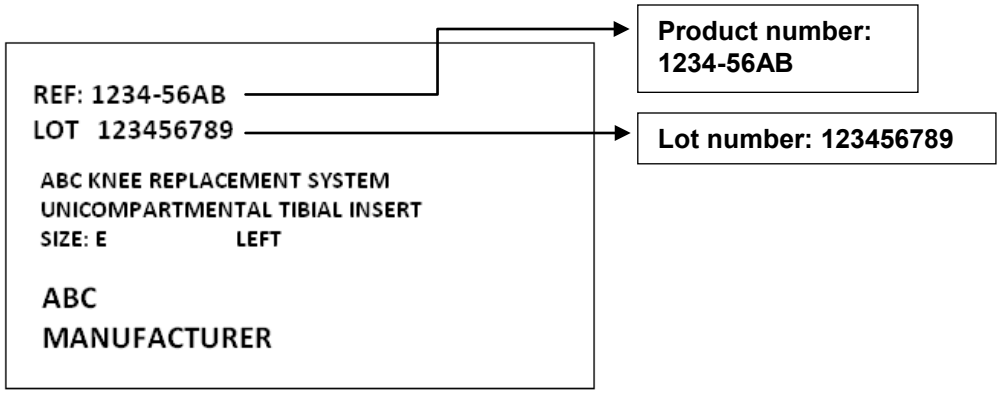
- For Zimmer products, the product number is often referred to as the EDI number.
  - If there is an EDI number, manually enter it in the implant Product Number field.
  - If there is no EDI number, manually enter the catalogue number (also known as the reference number) in the implant Product Number field.

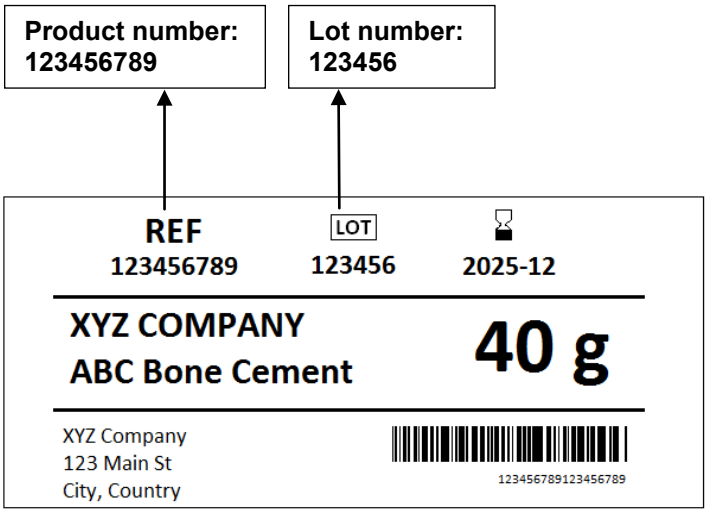


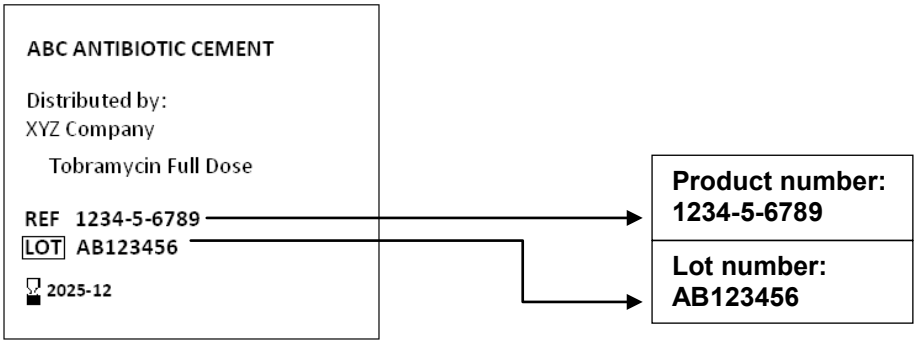


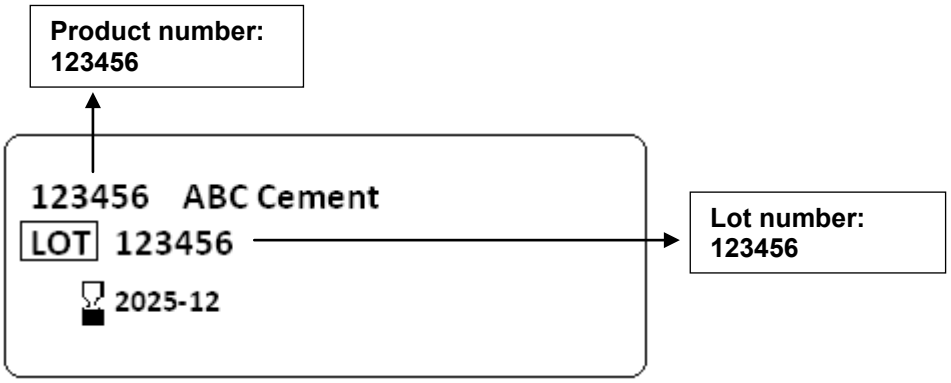
Sticker Examples for Manual Entry

This section presents a sample of fictitious product labels based on actual manufacturer stickers. This is not an exhaustive list; it is intended for demonstration purposes only.



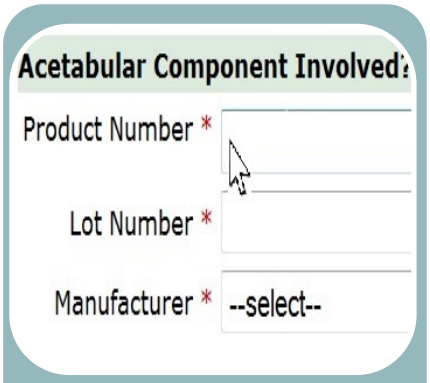





Product number:
123456
123456 ABC Cement
LOT 123456
2025-12
Lot number:
123456

Demonstration

This is an example of a product sticker with two unlabelled barcodes (that are not from the manufacturer Link).



Place computer cursor in the appropriate Product Number field (where you want the information to be entered).

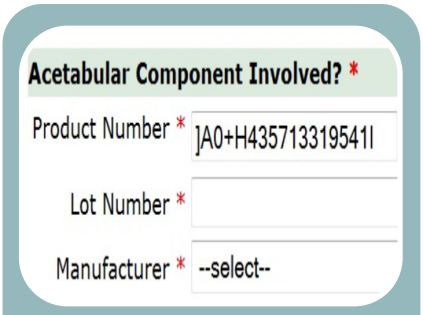
Align barcode scanner to product label. Be careful when scanning the barcode.

Scan the **top** number into the **Product Number** field.

Note: Ref Number = 71331954

Value under the barcode =

+H4357133195411



The resulting output should look like this.

Each scanned barcode should lead with a square bracket ( ]). If this is missing, it may be an indication that the AIM Code was not enabled. (See Step 1.)

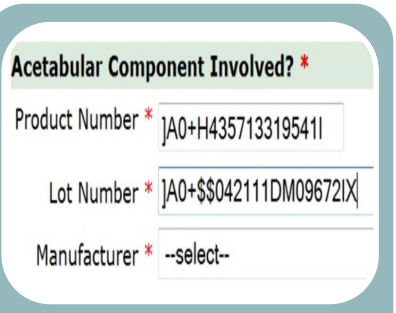
Note: It is acceptable for the output to look completely different than the value under the barcode. **Do not modify** the scanned output (for example, do not delete characters or symbols).

Scan the **bottom** barcode into the **Lot Number** field.

Note: Lot Number= 11DM09672

Value under the barcode =

+$$04211DM096721X



The resulting output should look like this.

Each scanned barcode should lead with a square bracket ( ]). If this is missing, it may be an indication that the AIM Code was not enabled. (See Step 1.)

Note: It is acceptable for the output to look completely different than the value under the barcode.

Do not modify the scanned output.

Note

French keyboard users: In place of the leading "]," scanned output will lead with a cedilla (either "¸" or "Ç").

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